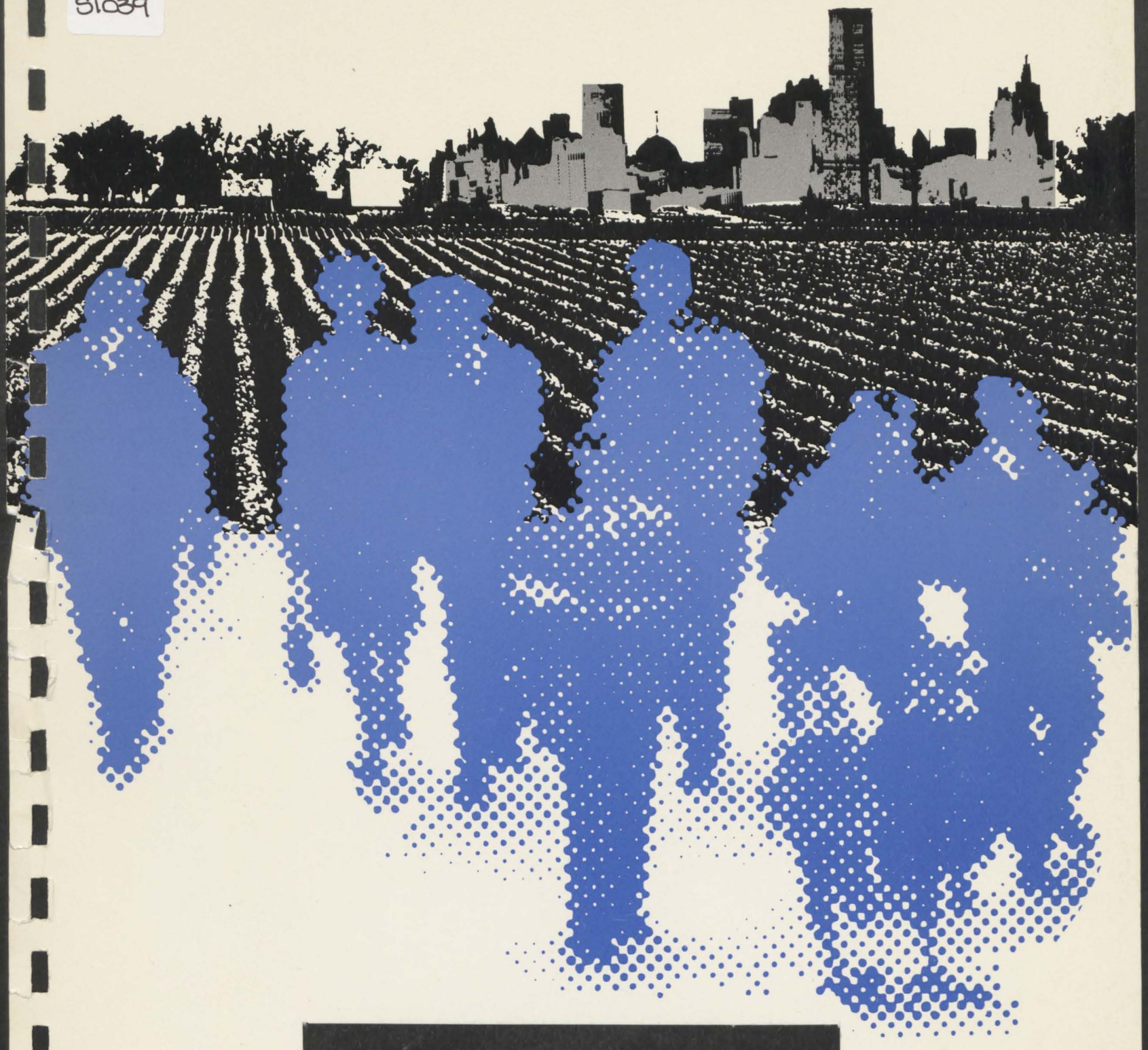

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Center for Urban and Regional Affairs

DOWN TO THE BONE:

COMMUNITY-BASED FACILITIES IN A TIME OF RETRENCHMENT

By Esther Wattenberg

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Esther Wattenberg
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*No longer with Hennepin County

FOREWORD

When this study was initiated in the spring of 1982, the slashes in the federal budget for social services as a result of the 1981 Omnibus Reconciliation Act sent shock waves that reverberated throughout state and local budgets. It is safe to assume that the budget cuts now being considered for the 1986 federal budget will have an even more jarring effect on the local budgets for social services. Once again, the message will be delivered: county budgets will be tight, and purchase-of-service agreements with community-based facilities will, once again, be striped "down to the bone." This study, dealing with the effects of the 1981-82 budget cuts, may offer lessons to be learned.

PART I: BACKGROUND

INTRODUCTION

This study was initiated to examine the impact of a period of fiscal austerity on community-based facilities that followed the enactment of the Omnibus Budget Reconciliation Act in 1981.[1] It was our intention to explore the consequences of budget uncertainty on the tier of social services that existed, chiefly, on purchase-of-service agreements with counties and then to project recommendations that might strengthen the partnership of community-based facilities with county governments. Several vulnerable groups are served by the community-based facilities under review; among the constituencies served we have: persons in need of physical health care as well as mental health and chemical dependency treatment; adolescents in need of supervision, protection, and treatment; children and adults in need of supervision and training who are developmentally disabled.

In order to avoid being mired down in the diverse and perplexing array of programs and constituencies as well as decision-making pressures that ultimately shape budget allocations, this study sought to select the most salient features for study.

To this end, the study is organized with a section on background delineating the organization of the social service delivery systems under review and the changing financial support sources for this system; observations from a survey of directors of sixty-five community-based facilities in the metropolitan area,[2] budget allocations drawn from county departments, and panel discussions of informed participants; case studies of two of the constituencies served by community-based facilities: troubled adolescents and the developmentally disabled; and finally a section on conclusions and recommendations.

* * * * * *

Think of the social service delivery system as a structure having three tiers. The foundation is the public social service tier. Responsible by law to serve certain vulnerable constituencies, it commands the largest amount of dollars and the largest number of clients served. Administered at the county level and supervised by the Minnesota Department of Human Services, it is supported by a variety of funding sources. In Minnesota, these combine to form a block grant allocated to each county under a formula designated by the Community Social Services Act.[3] The primary funding sources include federal Title XX Social Security Act dollars, state funding from appropriations to the Community Social Services Act, and local support from county tax dollars.

Another tier consists of traditional nonprofit private agencies, chiefly organized around services to families and children. These are supported primarily by a mix of United Way, sectarian, and public dollars. The public dollars come via contracts with counties in a mechanism known as a "purchase-of-service agreement."

Sandwiched between these two layers is a new tier. Here we find the community-based facilities, most of which are recent additions to the social service delivery system. Developed to serve special-needs populations, they are supported chiefly by purchase-of-service contracts paid for by public dollars.[4]

From time to time foundation dollars are available to all three tiers from special demonstration programs.

Community-based facilities had their origins in two movements that began during the late 1960s and early 1970s. One was a surge toward so-called "alternative" agencies, which began with demonstration projects that were part of the War on Poverty. It was hoped that these would prod existing social services agencies and bureaucracies into

responding more sensitively and effectively to the needs of poverty populations and other underserved groups.

The other movement was known as the "deinstitutionalization" effort. Also funded chiefly by public dollars, it was designed to create neighborhood-based day programs and residential facilities to provide for a variety of vulnerable groups who had previously been cared for in large state institutions.

These two initiatives shared some common characteristics. Their facilities were small in size and locally controlled. They sprang up in informal neighborhood settings--in store-fronts, rehabilitated vintage houses and church basements. Their staffing patterns reflected the paraprofessional movement that simultaneously grew out of the 1960s.

This period also witnessed several new "inventions": hot lines, neighborhood health clinics, runaway houses, feminist agencies, rape crisis centers, gay and lesbian services, group homes, and halfway houses. It even saw the birth of a publication, The Journal of Alternative Human Services,[5] which began publication in 1973 and continues today. The stability and persistence of these experimental modes was thus given an official stamp of recognition.

The ideology was clear, at least in the beginning. These agencies and services would compete directly with old-line agencies, but they would serve their constituencies in a purposefully informal and flexible way. Moreover, they would shake up the traditional institutions which, as was asserted in the rationale for the War on Poverty, were suffering from hardening of their aging arteries.

They operated in ways that were distinctly different from the traditional agencies. In a reaction to a perceived elitism of professionals in the human services, community-based facilities set out to bridge the gulf between workers and clients. Staff members were encouraged to speak, dress, and behave in a manner that would put people at ease. Some--especially in agencies dealing with drug and alcohol abuse--were (and still are) hired because of their personal experience with the condition that was to be treated; in fact, this was often considered the most important qualification an individual could bring to the job.

These agencies also stressed, in the beginning, the immediate availability of services, eliminating such bureaucratic barriers as waiting lists and rigid interpretations of eligibility requirements. Drop-in centers, weekend and evening clinics, and twenty-four hour crisis response were characteristic.

Extensive outreach further reflected their distinctive styles of operation. Bringing services "to the people"--in neighborhood settings, parks, and on street corners--was not uncommon.

Moreover, these agencies had a strong advocacy presence for their client groups. These service providers stressed self-help. Support groups were formed to address specific needs and issues. Staff members served as "facilitators" in group sessions which, characteristically, were designated as "informal helping networks."

Community-based facilities, responding to the wide spectrum of client groups, sprang from differing origins. Chemical dependency treatment programs had their origins in the corporate system, beginning as "employee assistance programs." Small group homes for the chronically mentally ill and the developmentally disabled developed as "ma and pa" enterprises in older, large homes in the center city that had been vacated in the rush to the suburbs. Residential treatment centers for disturbed youngsters were

developed chiefly by professional social workers, probation officers, and those with an experience with the earliest recorded purchase-of-service agreements: foster homes. Battered women's shelters, neighborhood crisis centers, and health centers were created by social activists of the 1960s and 1970s. The entrepreneurial spirit took hold and providers came forward to develop a variety of programs as part of the third tier of social services.

In time, community-based agencies and enterprises became permanent fixtures in the system, profoundly affecting the way in which many social services were delivered. Eventually counties began purchasing their services. It was assumed that this arrangement would give county agencies a degree of versatility and flexibility otherwise unavailable within their own bureaucratic environment. In particular, it was believed that market demands could best be met, and budget variations best adjusted to, if counties contracted with community-based providers on an annual basis. They would then be able to buy the services they wanted when they wanted them, and either renew or not renew their contracts as each new fiscal year rolled around.

Community-based agencies were perceived from the outset as independent and free from the personnel and program restrictions of large, formal, complex organizations. Administered by appointed or self-selected directors and loosely governed by advisory committees or boards, they typically operated with a great deal of autonomy.

Granted, this freedom was not won cheaply; nor was it absolute. Even in the beginning, funding was a problem. A constant search for dollars among federal, state, and local governments, as well as private sources, characterized this third tier. However, more and more the search shifted in the direction of annual purchase-of-service contracts with county agencies.

In time, community-based facilities became almost totally dependent on these contracts. Significantly, the purchase-of-service agreements came with strings attached. First, the unfettered style of operation was curbed by licensing requirements and guidelines that were backed by detailed rules and regulations. Secondly, the reliance on county dollars meant that they were accountable to the counties, although often in a vague and unsystematic way. In short, community-based agencies became, to a large extent, fiscal creatures of the bureaucracies. Yet the search for funding was still a top priority because county contracts were of brief duration and subject to the vagaries of county budgets. Staff members were forced to devote large portions of their time and energy to administering current contracts and soliciting new ones.

Perhaps reflecting this fiscal uncertainty, hiring tended to be confined to entry-level positions. These were usually paraprofessional in nature, low-paying, and unstable, and employees were given few opportunities for advancement. As a result, turnover was (and remains) high.

Despite these and other problems, community-based agencies continued to perform certain essential functions. For example, they offered a variety of social services focused on improving the capacity of vulnerable populations to live in the world. In many cases, day treatment, out-of-home treatment, and neighborhood facilities took the place of institutionalization. Not only did this shift some of the burden from state and county agencies; it also reflected a major change in thinking about how to care for these populations. "Normalization" became the core concept and community-based facilities, the vehicle.

Thus the agencies that began as experiments in the 1960s and 1970s ended up as integral parts of the social services system. People came to count on them and the services they provided. Counties came to count on them and the services they offered

for sale. The new tier they occupied became as necessary to the overall structure as the old-line public and nonprofit tiers.

In recent years, however, cuts in federal, state, and county budgets were rumored to have jeopardized the stability of community-based agencies. This study is devoted to an examination of how this third tier of the social service delivery system fared in an era of retrenchment.

Were they able to absorb the budget reductions? If so, how did they adapt to their losses? Were they responding effectively to "market" forces, diminishing or expanding as needs for their services changed? What emerging issues are these facilities having to face, and how sucessfully are they facing them? Are counties finding the versatility and flexibility in their contractual arrangements that caused them to enter purchase-of-service agreements in the first place?

THE CHANGING PICTURE: FINANCES, DEMOGRAPHY AND TREATMENT

One begins an examination of the Hennepin County and Ramsey County purchase-of-service budgets against the backdrop of fiscal constraints that prevailed in 1981-82. The federal government sent its signal. The Omnibus Reconciliation Act of 1981 effected cuts for social services and programs of 20-25 percent across the board. In addition, Supplemental Security Insurance (SSI), a federal program providing income maintenance for the mentally retarded and mentally ill, eliminated large numbers of persons who were arbitrarily identified as having "marketable skills," thereby losing their eligibility and their only source of personal income. General Assistance (a program funded chiefly by county dollars), a major source of funding for the maintenance of mentally handicapped persons in residential facilities, was considerably reduced. So were per diem rates and expenditures for out-of-home care. Funding from the Community Social Services Act (CSSA), the state source, increased somewhat, but not enough to make up for the loss of dollars from federal sources. Levies in some counties went to the limit of state ceilings for property taxes, but still the total budgets were diminished. The message was clear: money was tight, and it was going to get tighter.[6]

Demographic changes also took their toll. For example, the number of adolescents (the 14-16 age group) fell dramatically, according to Minnesota census figures. In 1970, there were 236,724 adolescents in the state; by 1980, this had dropped to 109,145--a 53 percent reduction. Since adolescents comprise a large part of the treatment population, this resulted in a significant change in "market demand."

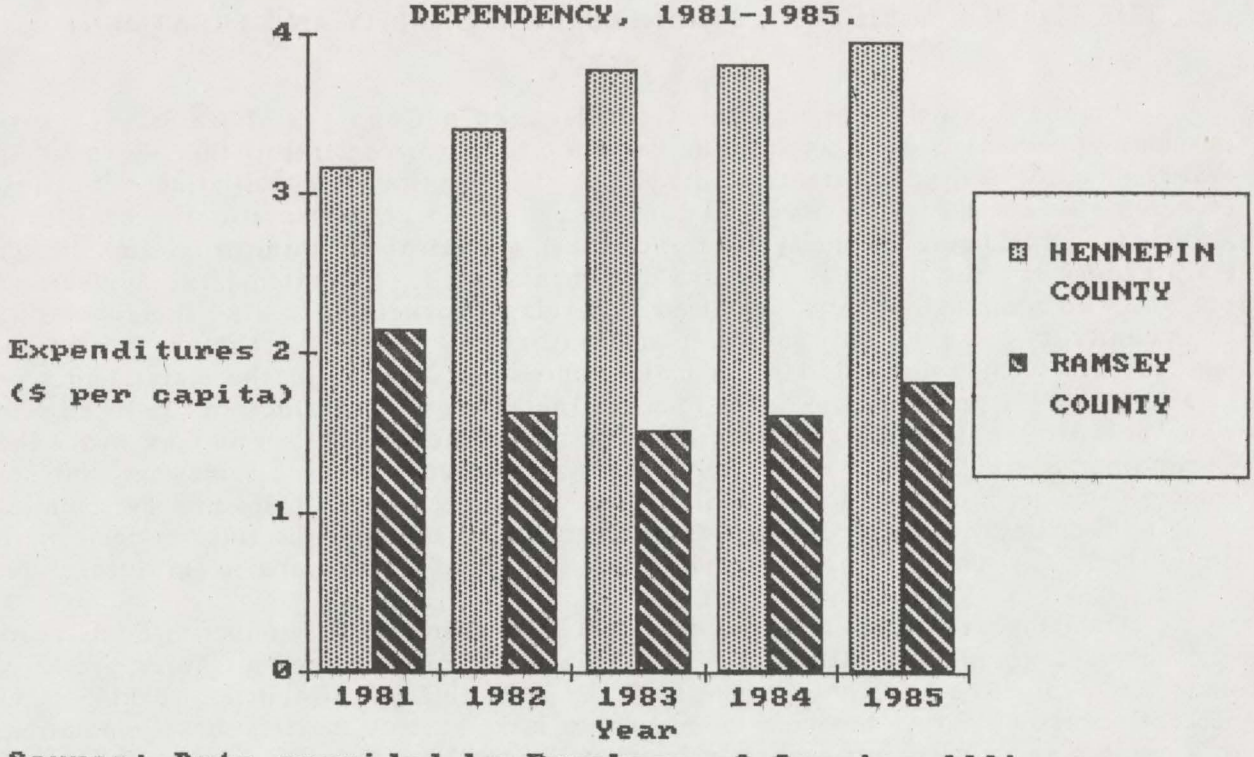
Further, at this time a shift in treatment emphasis was beginning to take place. Retaining the child or the chemically dependent person at home was the preferred treatment plan. The tendency to remove children in need of treatment and protection to foster homes and residential treatment centers was sharply curbed. Likewise in chemical dependency treatment, a shift toward non-hospital based treatment was occurring. These changes continued during subsequent years. Of striking interest, however, are the differing coping capacities and responses of counties to these general fiscal, demographic, and treatment changes.

The proportion of county budgets spent on purchase-of-service agreements with community-based agencies fluctuates from county to county and from year to year. In Ramsey County, for example, this budget item went from $8,360,617 in 1981 to $6,379,782 in 1982, a cut of almost two million dollars. This absolute shrinkage of substantial dollar amounts, along with the impact of inflation, resulted in a severe shock to the system of purchase-of-service contracts. By 1983, this budget allocation had risen to $7,416,479. By 1984, it had risen again to $8,165,433, almost reaching the pre-budget slashing year of 1981.[7]

On the other hand, the funding patterns for Hennepin County, the most populous county in the state, remained relatively stable during the crisis year of 1981-82 and beyond. Indeed, during that crunch year, a 9 percent increase to account for inflationary pressures was actually added to the contracted services budget. In subsequent years, "hold the line" budgets were maintained.[8] However, purchase-of-service agreements varied within program areas, with individual losses and gains throughout the system.

The roller coaster phenomenon endured by Ramsey County was not replicated in Hennepin County. The difference in the counties' response is seen, clearly, in the purchase-of-service agreements for chemical dependency treatment in Figure 1.

Figure 1. COUNTY PURCHASE-OF-SERVICE AGREEMENTS FOR CHEMICAL DEPENDENCY, 1981-1985.



Source: Data provided by Purchase-of-Service Officer, Hennepin County and Ramsey County.

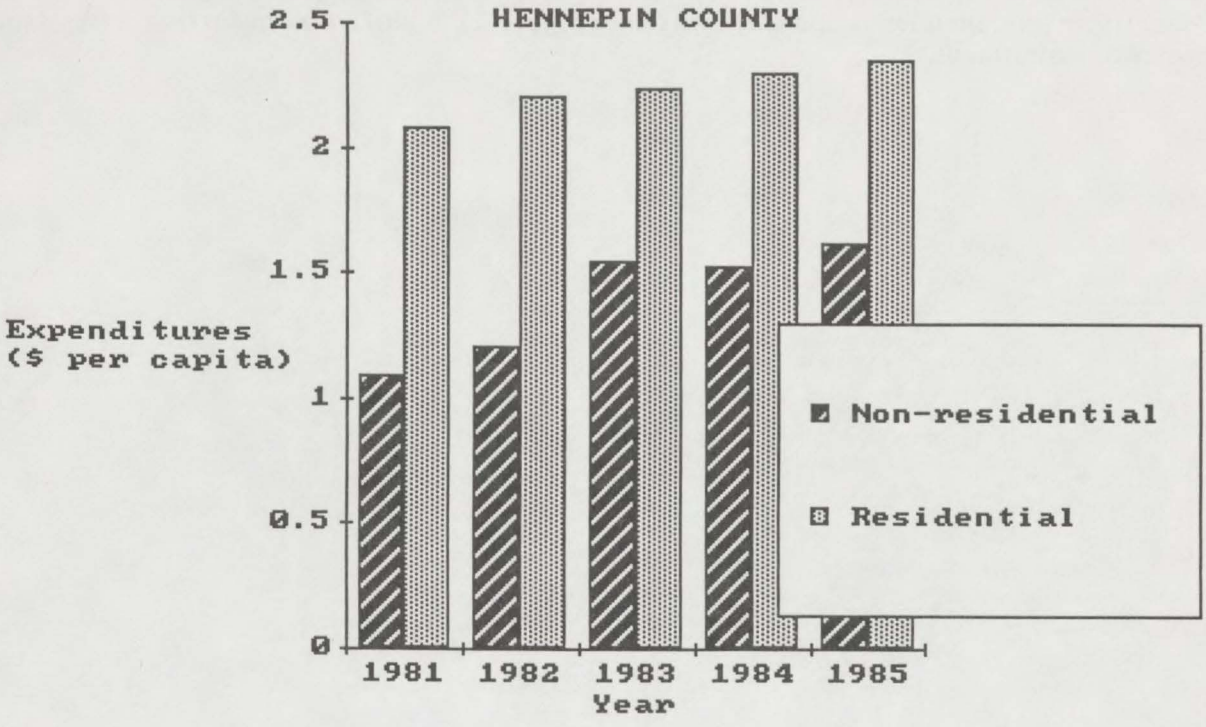
Two distinctive features mark the difference between Hennepin and Ramsey counties. While both spent substantial dollars for chemical dependency in purchase-of-service agreements (for Hennepin County an average of well over $3 million yearly from 1981 through 1985 and for Ramsey County an average of about $803,500 annually from 1981 to 1985), clearly, Hennepin County was willing to spend significantly more money per capita than Ramsey for this constituency (an average of $3.62 per capita annually in Hennepin County, compared to an average of $1.75 in Ramsey). Moreover, Hennepin consistently maintained and slightly increased its purchase-of-service budget over the years, whereas Ramsey slashed its contract agreements in 1982 and 1983. Although Ramsey added some dollars in subsequent years, it never recovered to the level of funding that was established in 1981.

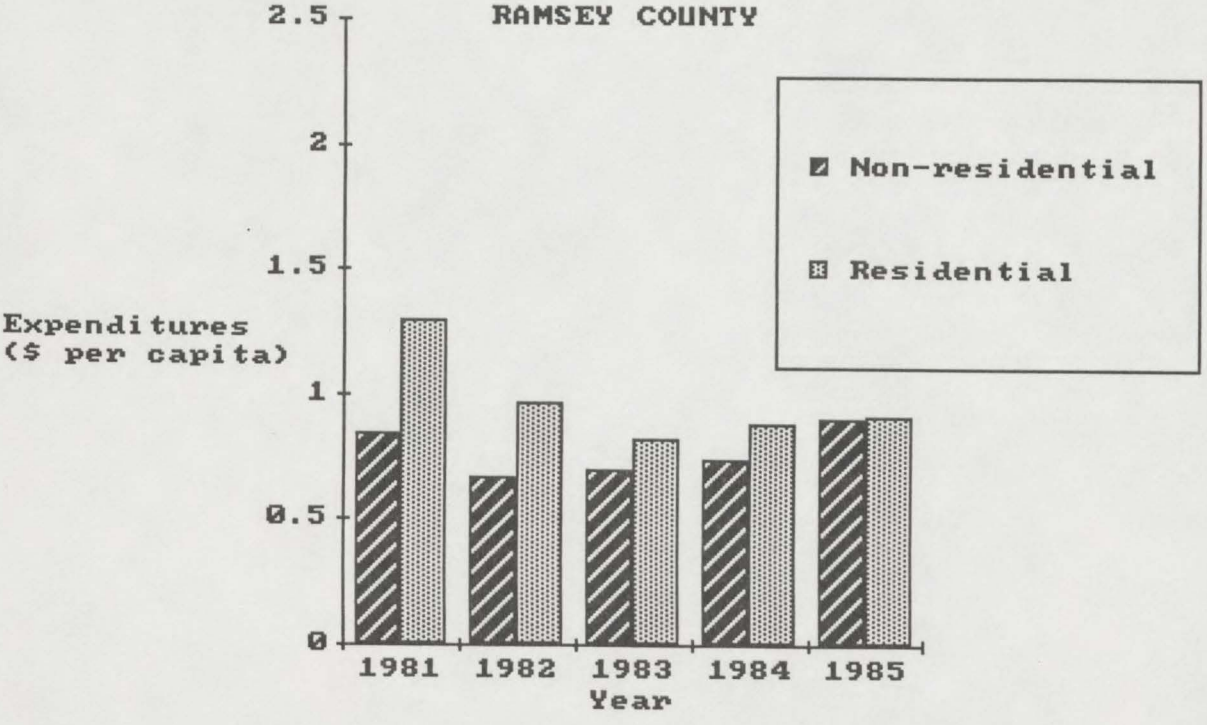
During this retrenchment period, both Hennepin and Ramsey counties suffered from the impact of a recession economy as well as changes in the demographic composition of their populations. What, then, accounted for their differing adaptations to the financial crunch?

Clearly, one factor is the differing tax base between these two urban counties that are geographic neighbors. Ramsey County has a lower tax base for levies for social services than Hennepin, reflecting differences in available property for tax purposes. Further, there appears to be a difference in their financial capacity to cope with unexpected financial crises. Ramsey County operates a budget "close to the edge," whereas Hennepin County can count on reserves and contingency funds for its fiscal emergencies. Moreover, the political orientation of the county commissioners may also play a role. Observers frequently point out the conservative orientation of Ramsey County commissioners and the liberal position of Hennepin County commissioners as important factors in budget allocations.

Somewhat related to budget austerity but emerging on its own as a factor in change, was the growing emphasis on non-residential treatment as a preferred treatment orientation. Illustratively, a portion of the human services budget that might otherwise have gone for out-of-home placement of children in a purchase-of-service agreement went instead to intensive services with families, chiefly an "in-house" operation. As we see again in the chemical dependency arena (Figure 2), a shift was occurring away from residential treatment.

Figure 2. COUNTY PURCHASE-OF-SERVICE AGREEMENTS FOR RESIDENTIAL AND NON-RESIDENTIAL CHEMICAL DEPENDENCY TREATMENT, 1981-85.





While both counties were moving programmatically to a wider use of non-residential treatment, Ramsey actually reduced its spending on residential facilities. By 1985 it had achieved parity, spending equal amounts for residential and day treatment. Whereas Hennepin County maintained and even increased slightly its contract budgets with residential facilities, while at the same time increasing the budget allocation for non-residental facilities.

Finally, budget procedures were changing. Unit budgeting began replacing guaranteed payment in some instances. Payment was made on the basis of cost per unit for actual use, replacing the purchase of a block of "slots" for a predicted pattern of use.

Furthermore, the growing emphasis on program accountability was producing changes in budget procedures. This had it orgins in the 1970s and accelerated as a result of the money crunch in the 1980s. With an increased emphasis on evaluation, community-based programs and services feared that those who did not measure up to some vague criteria would have their lifeline--county contracts--snatched away.

In summary, the environment in which negotiations for purchase-of-service contracts take place is rarely in a steady state. Turbulence accompanies each fiscal year. When this study commenced in 1982, an air of apprehension and anxious cost-consciousness pervaded the system. A loss of substantial dollars from federal and state sources was occurring, reflecting a recession. A drop in referrals was expected throughout the community-based facilities system. Officials in both Hennepin and Ramsey counties issued a series of administrative directives[9] that were subsequently incorporated into contractual understanding. Key points included:

- Facilities would be more closely monitored and evaluated.
- More stringent eligibility rules for services would be instituted.
- Briefer periods for residential and day treatment would be imposed.

This study was then initiated in order to examine the impact of the initial stage in a retrenchment period on facilities that were heavily dependent on purchase-of-service contracts.

PART II: THE SURVEY

SOURCES OF DATA

This study relied on three levels of analysis:

- A survey of sixty-five community-based facilities, represented by neighborhood health centers, chemical dependency facilities, adolescent group homes and treatment centers, and facilities for the developmentally disabled and the chronically mentally ill.[10]

- An examination of budget reports from contracts filed in Hennepin and Ramsey counties' purchase-of-service offices. Details on procedures and policies which shaped the budget decisions were contributed by state and county administrators in additional interviews.

- A case study of two vulnerable populations was selected for exploration to see what actually happened to programs as a result of retrenchment. The observations from the case studies were amplified by panel discussions and reports prepared by the Developmental Disabilities Program, Legal Advocacy for Developmentally Disabled Persons in Minnesota, and the Community Social Service Act (CSSA) reports of the Minnesota Department of Public Welfare, now renamed the Department of Human Services.

The study was limited to community-based facilities in Hennepin and Ramsey counties.

Because there is no single and uniformly accepted definition of what a community-based facility is, we focused only on those that met the following four criteria:

1. Recently created (in 1970 or later) or facilities that were recently developed under the umbrella of older existing agencies.

2. Serving a "special needs" population.

3. Receiving major funding on a contract-for-service basis with either Hennepin or Ramsey counties, or from some other public source.

4. Located in the metropolitan area and operating in a neighborhood setting.

Seventy-three facilities were identified, but only sixty-five interviews provided useful data. See Appendix A for a complete list. The facilities served the following populations: chemically dependent youth (4); chemically dependent adults (6); chronically mentally ill adults (9); the developmentally disabled (9); the physically and mentally handicapped (3); dependent and delinquent adolescents in out-of-home placements (15); and women in vulnerable situations (7). Also included were neighborhood health clinics (11) and one refugee resettlement program. Excluded were child care facilities and community facilities for the elderly, since these existed, to a large extent, prior to 1970. While the list may not be complete, it is, in our judgement, representative of the range of programs and facilities located in neighborhoods on a purchase-of-service agreement to serve the populations designated above.

Although the questionnaire did not address this topic, we were interested in learning how the various facilities had come into being, and we gathered this information along the way. We found three prevailing structures:

1. Five traditional, long standing social service agencies initiated community-based facilities under their auspices. For example, the Wilder Foundation has sponsored five residential treatment facilities and group homes for adolescents, and St. Joseph's Home for Children operates a number of programs including a shelter, a day-treatment facility, and a residential long term facility.

2. Other facilities (three, in our survey), were set up as "franchises;" in other words, they belonged to a chain of facilities operated by a central administrative unit. Nekton, for example, which operates on a for-profit basis, runs sixteen group homes for the mentally retarded under the Department of Public Welfare's Rule 34: twelve in the metropolitan area, and four in Duluth.

3. Finally, the remaining facilities were free-standing, operated independently by individuals or groups of individuals in partnerships. The City/Southside and Freeport West are examples of independent, free-standing programs.

We noted that Nekton operates on a for-profit basis; it is not the only facility we studied that does. On the other hand, many are strictly non-profit. We found that differences between profit and non-profit facilities were not apparent either to county officials, directors of facilities, or to the consortiums that represented many of the programs. Specific research on differences between for-profit and non-profit programs is yet to be developed.

FINDINGS FROM A 1982 SURVEY: INTERVIEWS WITH FACILITY DIRECTORS

Our interviews focused on learning how a sampling of community-based facilities had been affected by the 1981-82 changes. The following sections contain some of the facts and figures we gathered, along with observations on their implications.

STAFFING PATTERNS

As is characteristic of community-based facilities, those surveyed had small staffs ranging, generally, from six to eight employees.

Also characteristic were low salary levels. In 1981, the average hourly wage for personnel working in Developmental Achievement Centers (DACs)--facilities providing day programs and services for the developmentally disabled--was $7.06 for employees with college degrees, or just under $15,000 per year. For employees with less than a four-year college degree, the average hourly wage was $4.78, or just under $10,000 per year.[11] Seventy-eight percent of the direct service workers in this area earned less than $15,000. In the youth chemical dependency area, where salaries were somewhat higher, 50 percent of the direct service workers earned less than $15,000.

Salaries across the board were considerably below those earned by mental health and social service professionals in the private sector, and by civil service employees in public agencies.

The direct service workers tended to be young; many were still in college. The jobs appeared to be entry-level, geared to paraprofessionals--a staffing pattern that has been shown to result in high stress and high turnover.

Furthermore, employees often assumed several roles, depending on day-to-day circumstances. It was not unusual for a typical worker to function as a counselor, house-parent, cook, monitor, guard, or administrator, switching informally from one to another as the need arose. There were few discernible roads to advancement. Not surprisingly, one-third of the employees in our sample worked part-time.

How might staffing patterns change in the event of further budget cuts? Significantly, from all reports. Most facilities' budgets are already absorbed by personnel costs. The "labor-intensive" nature of these enterprises has made the direct service providers (counselors and maintenance personnel) especially vulnerable. Fifty-five percent of the facilities surveyed were contemplating changing, or were in the process of changing the ways in which they used direct service workers. The possibilities most frequently mentioned included downgrading some positions from full-time to part-time and laying off personnel. Attrition, resignations, and the elimination of services were next in order. "We're already down to the bone," one subject commented. "I don't know how we'll manage."

Little change was expected in management and clerical staffs, given that these positions tended to be held by one person doing double duty.

Both during the time these interviews were conducted and somewhat later, it was disclosed to us that the downturn in employment among social workers was resulting in an influx of highly credentialed individuals. We heard of a number of Ph.Ds and MSWs who had found jobs in community-based facilities--doubling as counsellors and cooks.

CLIENT CHARACTERISTICS

The community-based facilities included in our study served both men and women and a wide range of age groups. One-third focused exclusively on adolescents and young adults, a population requiring special out-of-home care arrangements. Small group homes, an invention of the 1970s, were created to provide an alternative to the foster homes and large institutional settings where certain youths requiring out-of-home care had traditionally been sent.

More than half of the facilities we surveyed were geared toward low-income and poverty-level clients. But a substantial number offered their services without regard to income. Of all individuals who used the facilities in our sample, 31 percent paid for their care through third-party payments, indicating that either they or their families had insurance coverage.[12]

More than three-fourths of the clients came from Hennepin and Ramsey counties. (Recall that we limited our study to facilities in the metropolitan area.) Fifteen percent lived outside the metro area but were served in facilities in Hennepin and Ramsey counties due to special needs. The residence of 10 percent of the clients was unknown.

The length of time for which clients received services ranged from thirty days to six months; over one-third received services for four months or less. Such brief periods of involvement are in keeping with the original purpose of community-based facilities: to provide short-term counseling, support, health, and employment-related services, for the "normalization" process. Exceptions, of course, are those facilities developed for the chronically mentally ill and the developmentally disabled, for which the objective is one of maintenance within an extended program of activities.

IMPACTS OF BUDGET CUTS ON PROGRAMS

To accommodate to the actual or expected reduction in funding, more than two-thirds of the facilities surveyed intended to change their eligibility requirements in order to attract clients with third-party payments. Unable to serve the working poor who were now ineligible for government support because of tightened eligibility rules, 66 percent of these facilities planned to make referrals to other agencies. Particularly affected were those facilities which served members of families who, typically, did not have private insurance coverage: youth chemical dependency facilities (75 percent), those serving the developmentally disabled (67 percent), and neighborhood health clinics (82 percent).

Significantly, 45 percent planned to reduce staff training, and 11 percent planned to eliminate it altogether. This is a matter of great concern. The interaction between staff member and client is intimate and, to some extent, unsupervised. Most direct service workers are paraprofessionals without much training behind them, and further training is almost always needed--both for the sake of their own career development and for the sake of their clients. Curtailing training would almost surely affect the quality of the services delivered.

The majority of the facilities in our sample expected to continue their needs assessment and outreach programs, in keeping with the requirements of their county contracts. Other requirements were becoming more difficult to meet. For example, the increased emphasis on accountability meant that direct service workers were spending more time on the administrative tasks of reporting and less on client-focused activities. Almost all respondents claimed that this was a high price to pay for paperwork.

While nearly 77 percent intended to make more use of volunteers, this source of support is widely regarded as having certain limitations. It was pointed out that many client groups are difficult to work with, and that involvement with them does not give volunteers the personal satisfaction they often require. Some providers told us that they had attempted to recruit and train volunteers to work with the adult developmentally disabled, and that the results had been less than satisfactory. The volunteers had been "unreliable" and "undependable;" it was "easier to find volunteers for children."

In addition, finding and supervising volunteers takes time and effort. Not only must staff members develop outreach strategies and implement them in their communities; they must also take responsibility for the volunteers who appear on their doorstep. Most staff members, already overburdened, were not keen on the idea of assuming these extra duties.

Also relevant is the issue of whether facilities ought to call attention to themselves by recruiting volunteers. One informant maintained that it was better to maintain a "low profile." The process of locating a facility within a community is usually accompanied by intense controversy; once the facility is in place and operating, keeping quiet about it seems the best strategy for survival, according to several informants.

In some facilities, such as neighborhood health clinics, volunteers have long been a part of the service delivery system. Most facilities agreed that a strategy of substituting volunteers for paid staff would be inappropriate, and in fact, impossible.

IMPACTS OF BUDGET CUTS ON CLIENT GROUPS

How were clients affected by these changes in county funding patterns, and the adjustments community-based facilities were forced to make in response to them? According to personnel employed at the facilities we surveyed, the cuts were having a number of harmful effects.

Seventy percent reported that clients appeared to be having more serious problems than in the past. Indeed, the common observation was that clients were not being referred to community facilities until they were in crisis situations. The "preventive" use of facilities had declined and, in some cases, almost disappeared. "Benign neglect" was described as "the order of the day." Only when clients were in deep trouble were referrals being made.

Due to dwindling staffs and increased evaluation and reporting requirements, direct service workers were able to spend far less time serving clients.

The picture emerges, then, of an increasingly overburdened staff attempting to serve clients in more seriously disturbed conditions than in the past.

Large numbers of clients were having problems related to income maintenance. Furthermore, transportation, utilities, housing, fee payments, and child care were all cited as concerns by persons in day treatment.[13] For residential clients, the briefer periods allowed for treatment were resulting in inappropriately timed discharges into unstable situations.

On the topic of tighter eligibility requirements, respondents predicted that the "working poor" were likely to be denied access to community-based facilities in the future. Their incomes were often just above the eligibility level, and they were unlikely to be covered by third-party payments. The opinion was expressed again and again that

a return to institutionalization in state hospitals was inevitable for many family members of this marginal group.

These observations, frequently expressed are pertinent here:

- There will be a growing pressure to maintain numbers in state institutions. The political power of state hospital lobbyists was often noted as being considerable in the movement to re-institutionalize the special needs population that were served by community-based facilities.

- Single men and women with handicaps of various kinds are especially disfavored in the current environment of fiscal cutbacks. Cuts in General Assistance for maintenance precipitated a crisis that became visible in the increased numbers of men and women seeking shelter in emergency facilities.

- Fewer requests for placement in residential treatment centers means that other parts of the system are being used for the vulnerable populations under review: correctional facilities, state institutions, private psychiatric facilities, and day treatment.[14]

- Strict time limitations in the uses of community-based facilities meant that clients were often discharged into unstable and often harmful environments.[15]

The long term effects on clients enmeshed in a system where treatment needs are subordinated to reimbursement and fiscal concerns was a persistent theme in the interview responses.

These observations were frequently expressed:

- Further reductions in staff which are already "down to the bone" will necessitate accepting only those clients who are easy to handle. "Creaming" (accepting only those clients deemed responsive to short-term treatment) will subvert the basic concept of community-based facilities as "a normalizing" experience for a wide range of formerly institutionalized persons.

- Family members of "the working poor" will not have access to services; their income and assets placing them just above income guidelines for eligibility for public funds and their lack of private health insurance eliminating them from third party payments.

IMPACTS OF BUDGET CUTS ON FISCAL PLANNING

In anticipation of further budget cuts, 60 percent of the facilities surveyed were contemplating fund drives. Almost three-quarters had approached foundations or were planning to. One-third had also explored the prospects of additional funding or substitute funding through United Way. Clearly, it was hoped that the private sector would assume some of the losses sustained as a result of cuts in public support. As we shall see, this did occur to some extent.

Fifty-two percent were considering installing a fee for service; 75 percent of the youth chemical dependency facilities and 100 percent of the neighborhood health clinics already had. The observation was made that if this were to become a dominant feature of program financing, families of the "working poor" would have minimal access to services.

Eliminating services was viewed as a viable option by 49 percent, as long as other parts of the social service system would pick up such items as health services, intensive counseling, and working with families of disabled persons.

Eliminating staff (60 percent) and freezing salaries (35 percent) were other possibilities mentioned. Given the meager size of most staffs, however, further reductions would be enormously difficult to implement.

Generally speaking, improvements to physical plants had been postponed or cancelled.

By the spring of 1982, the spectrum of community-based facilities began to struggle with the fact that the established resources within county budgets were drying up. Decisions on purchase-of-service agreements were likely to be "accountant driven." They began to search for ways to lessen their dependence on the local public dollar.

It soon became apparent, however, that there were wide variations in the coping capacities of community-based facilities. Political pressure of providers and of the client group, demography, and changing treatment plans were all going to exert their influence on county budgets.

In summary, it is at the county level that federal and state mandates for the human services come to rest. It is the county that must grapple with a wide variety of human conditions, including those disabled by alcohol and drugs, the adolescents in need of protection and treatment, and the developmentally disabled in need of social services. The retrenchment era initiated by the 1981-82 recession economy affected purchase-of-service contracts, of course, but Ramsey and Hennepin counties responded differently, and each constituency fared differently under the budget cutting knife.

BEYOND 1982: EXPLORATORY OBSERVATIONS

What occurred after the crisis year of 1982? In the period that followed, 1982-1985, federal dollars continued to be withdrawn, state budgets were barely maintained, and counties continued to be sent the message of fiscal retrenchment for human services: "Do more with less." While retrenchment fever did not subside, "crisis" was replaced by "adaptation," and a central fact emerged: with federal and state mandates, counties had less than 10 percent of their human service budgets over which they had some discretionary options.[16] The purchase-of-service agreements came under even more rigorous scrutiny than before.

The predictions of the survey respondents in 1982 had a mixed outcome.

The reinstitutionalization of client groups, such as the developmentally disabled and the chronically mentally ill, did not, in fact, take place. Legal decisions and treatment orientations preserved community-based facilities as a preferred option. The extent of "creaming," i.e., accepting only clients that are amenable to short term treatment, is not known. Rigorous follow-up studies have not been instituted. However, anecdotally, providers insist that creaming takes place to accommodate a shrinking of personnel; which is the principal way in which facilities absorb budget cuts.

Whether or not the "working poor" have been excluded from services with the wider use of fees and changing eligibility can also not be documented with objective data. Again, providers observe that outreach to this group is minimal. Further, preventive services with their long term focus are not central to services. The increased number of single men and women among the growing numbers of homeless requiring emergency shelter is frequently mentioned as a direct outcome of a lack of preventive services.

These are, however, general abstractions, derived from random observations from associations of providers and their spokespersons. Few, if any, client impact studies in this retrenchment era have been initiated. One turns, then, to observable data derived from budget allocations, noting, once again, that each constituency fares differently under the annual review of purchase-of-service agreements. Illustratively, two sectors are selected for updated observations.

In the chemical dependency sector, as we see from the budgets of 1981-1985 (Figures 1 and 2, pp. 7 and 9), Hennepin County holds the line with consistent expenditures in residential treatment and increased expenditures for non-residential treatment. In contrast, Ramsey County slashed its budget over the years, never regaining its 1981 level but bringing its expenditures for residential and non-residential contracts into parity. However, only two facilities were closed. The provider group remained relatively stable.

It is important to note that while the counties were in a retrenchment environment, a phenomenon was taking root outside of purchase-of-service agreements with public dollars: the discovery that some clients were capable of paying for chemical dependency services through health insurance plans.[17] The entrepreneurial spirit expressed through aggressive marketing efforts of programs and facilities in their search for clients soon earned the chemical dependency sector the reputation of becoming a growth industry. Hospital-based programs and expanded private for-profit clinics flourished. They developed the capacity to secure multiple sources of funding with a diminished interest in pursuing public dollars through purchase-of-service agreements.

In examining individual contracts with Hennepin and Ramsey counties, one realizes the special nature of the constituencies served by purchase-of-service agreements: ethnic minorities, the elderly, adolescents, low income individuals. The community-based facilities serving these client groups assert that they are operating "down to the bone" and any further reductions will severely hamper their programs. But the message is clear, at least from Ramsey County: short length of stays for clients in residential treatment and, whenever possible, avoid hospital-based treatment.

Both counties watch this sector of purchase-of-service agreements with apprehension, however. As General Assistance is whittled away, and the definition of "disabled" may come to mean a problem of alcohol or drug dependency that requires treatment, it will be harder to squeeze this portion of county budgets if retrenchment fever persists through 1986 and beyond.

Turning to neighborhood health clinics, one observes that they emerged from the early years of the retrenchment era with a strong and successful pursuit of diversified funding sources. It is worth noting that neighborhood health clinics, a product of the early 1970s, were "War on Poverty" experiments supported first by federal grants and later by purchase-of-service agreements with county dollars. Located in store fronts and abandoned or little used churches, they were intended to provide health care to neglected and underserved populations such as the "working poor." In time, they became permanent fixtures of the health care delivery system and formed a consortium.

Those clinics tied to Hennepin County for funding scraped through the 1981-82 budget crunch and in succeeding years were given budgets of a maintenance nature, with very little cost of living augmentation. Clinics tied to Ramsey County suffered significant losses of dollars. Early in their history the clinics formed a consortium. The response of this umbrella organization was to pursue a vigorous diversification of funding sources. The success of these efforts is revealed in the fact that by 1984, neighborhood clinics increased their private sources of funding (United Way, foundations, bake sales, etc.) from 2-3 percent in 1980 to 14 percent in 1984; their patient fee sources (chiefly Medicaid and Medicare) from 15-20 percent in 1980 to 34 percent in 1984; and their in-kind contributions from hospitals and volunteers from 1-2 percent in 1980 to 6 percent in 1984. Consequently, their reliance on purchase-of-service agreements diminished substantially. In 1984, county dollars, through purchase-of-service agreements, constituted less than half (46 percent) of the budgets of the fourteen clinics that are members of the consortium, a decline from 75 percent of their budgets in 1980.[18]

By 1985, an independent fund drive, the Community Health Fund, was developed to ensure a broad base of financial support for the clinics. Nevertheless, wide variations exist in the capacity of individual clinics to survive, and all clinics have initiated a sliding fee scale in order to recover some costs of care. No systematic study exists on the effects of the fee schedules on the "working poor." The information is chiefly anecdotal. Doctors and nurses report that, generally, there is a delay in coming in for treatment; preventive health care is not routinely sought, and patients on the whole seem "sicker," when they do come in for treatment. The sliding fee scale, which generally requires $10 for a visit, appears to have had some "chilling" effects on very low income persons.

The neighborhood health clinics offer a striking example of a sector in the community-based facilities arena which pursued fundraising outside of county contracts. Whether or not this weakens the clinics' ties to the county and diminishes their interests in responding to the counties' needs remains to be seen.

As the foregoing illustrates, each sector of the purchase-of-service arena has distinguishing characteristics. To grasp the complex array of factors that shape and reshape decisions in purchase-of-service agreements, two vulnerable populations are selected for closer examination: troubled adolescents and the developmentally disabled.

PART III: CASE STUDIES

Troubled Adolescents and the Developmentally Disabled

BACKGROUND

To illuminate the differing environments for decison-making, we examined two types of community-based facilities serving emotionally disturbed adolescents and developmentally disabled or mentally retarded persons in the Minneapolis-St. Paul metropolitan area: (1) adolescent residential treatment programs governed by Rule 5 and Rule 8[19] and (2) Developmental Achievement Centers (DACs), facilities that are part of a complex array of services for the mentally retarded.[20]

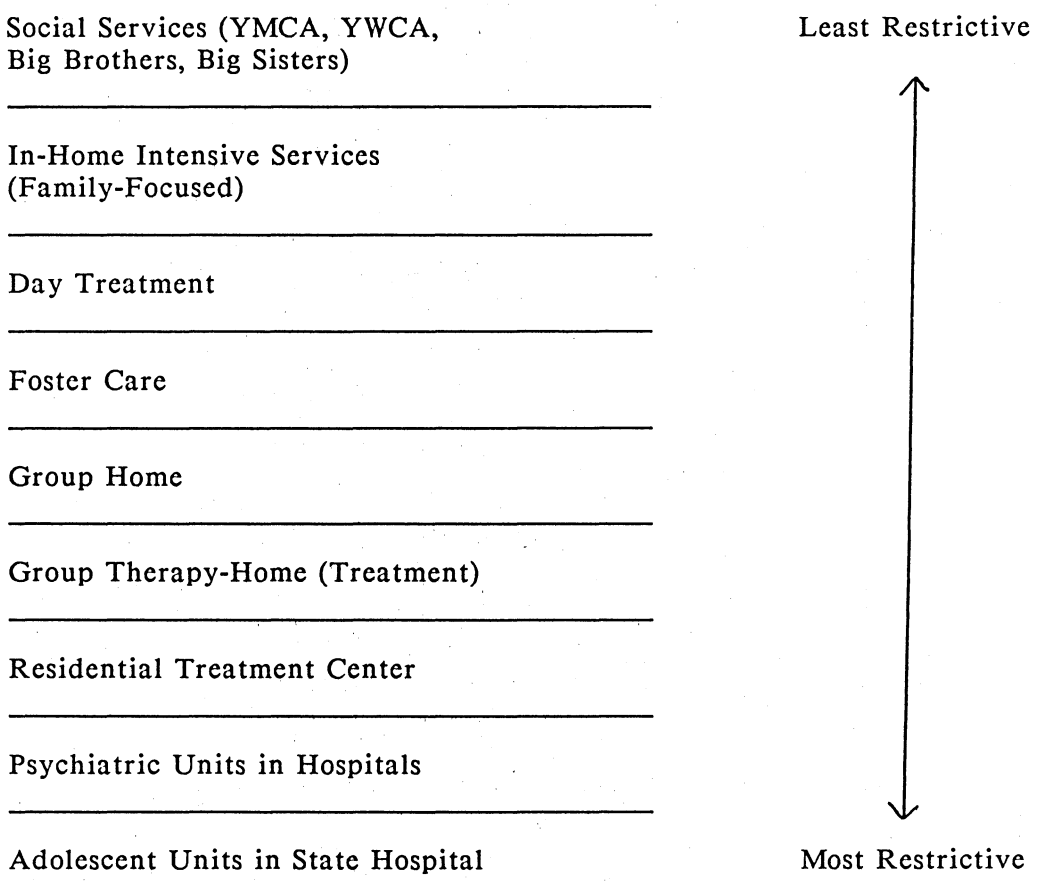
While examining the impacts of budget changes on these two types of facilities, each of which deals with a vulnerable population, we noted a number of similarities and differences.

To begin with, each operates within a system which offers an array of services, guided to some extent by a "continuum of care" concept; that is, the services available form a continuum from least to most restrictive.

For example, some 300 facilities geared toward the troubled adolescent population have come into being statewide over the last two decades. These reflect the variety of circumstances and behaviors that bring adolescents into the child welfare system (which is chiefly concerned with neglect, abuse, dependency, and emotional disturbance) and/or the juvenile justice system (which is primarily interested in delinquency). Facilities range all the way from social services such as those offered by the YMCAs and YWCAs and the Big Brother and Big Sister organizations, to locked wards in state institutions.

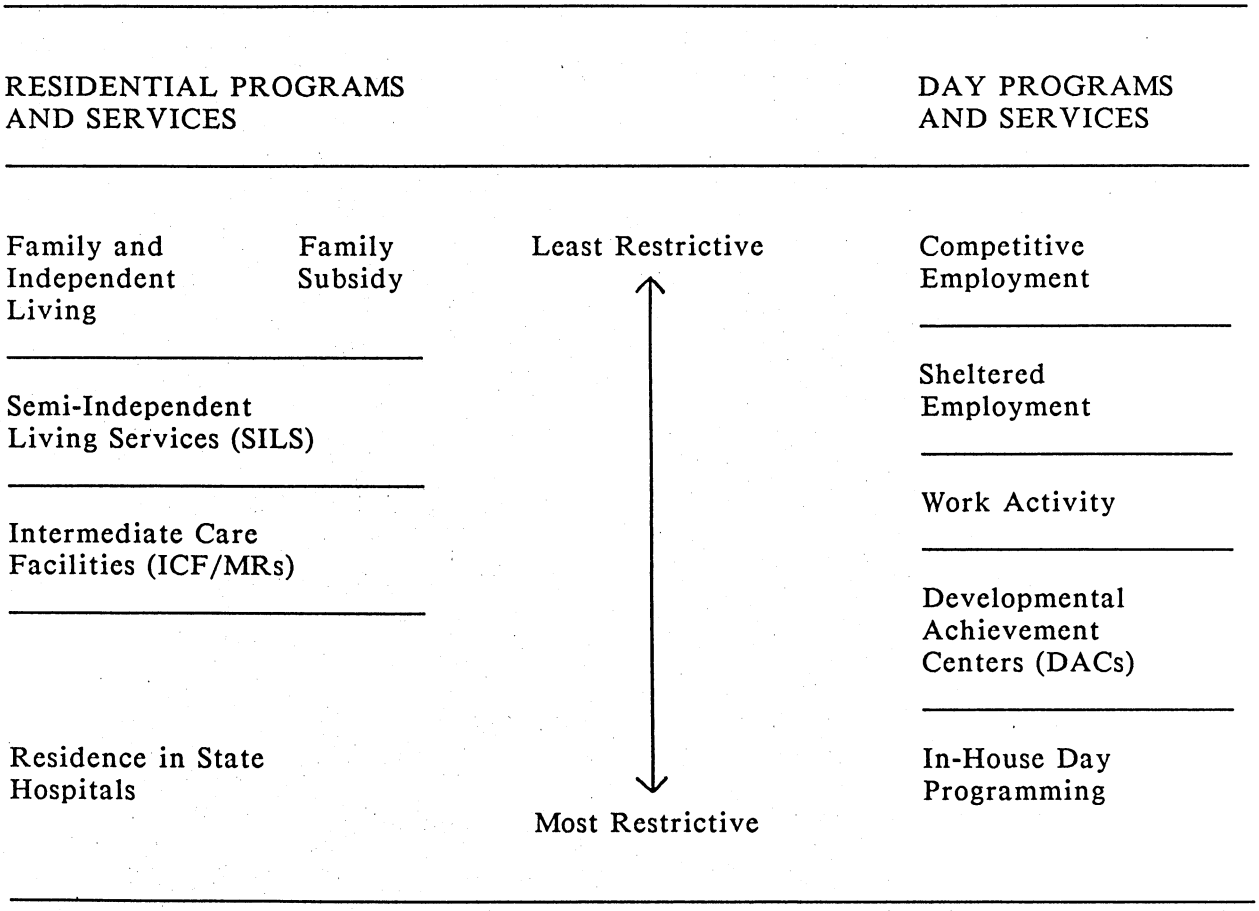
Figures 3 and 4 illustrate the "continuum of care" concept as it applies to each population.

Figure 3. SERVICES FOR ADOLESCENTS: A CONTINUUM OF CARE*



*Some adolescents supervised by the correctional system and the child welfare system float back and forth within the continuum. Long term care facilities are emerging as an option for youngsters who require a long term placement for training in adaptive skills in a protected environment.

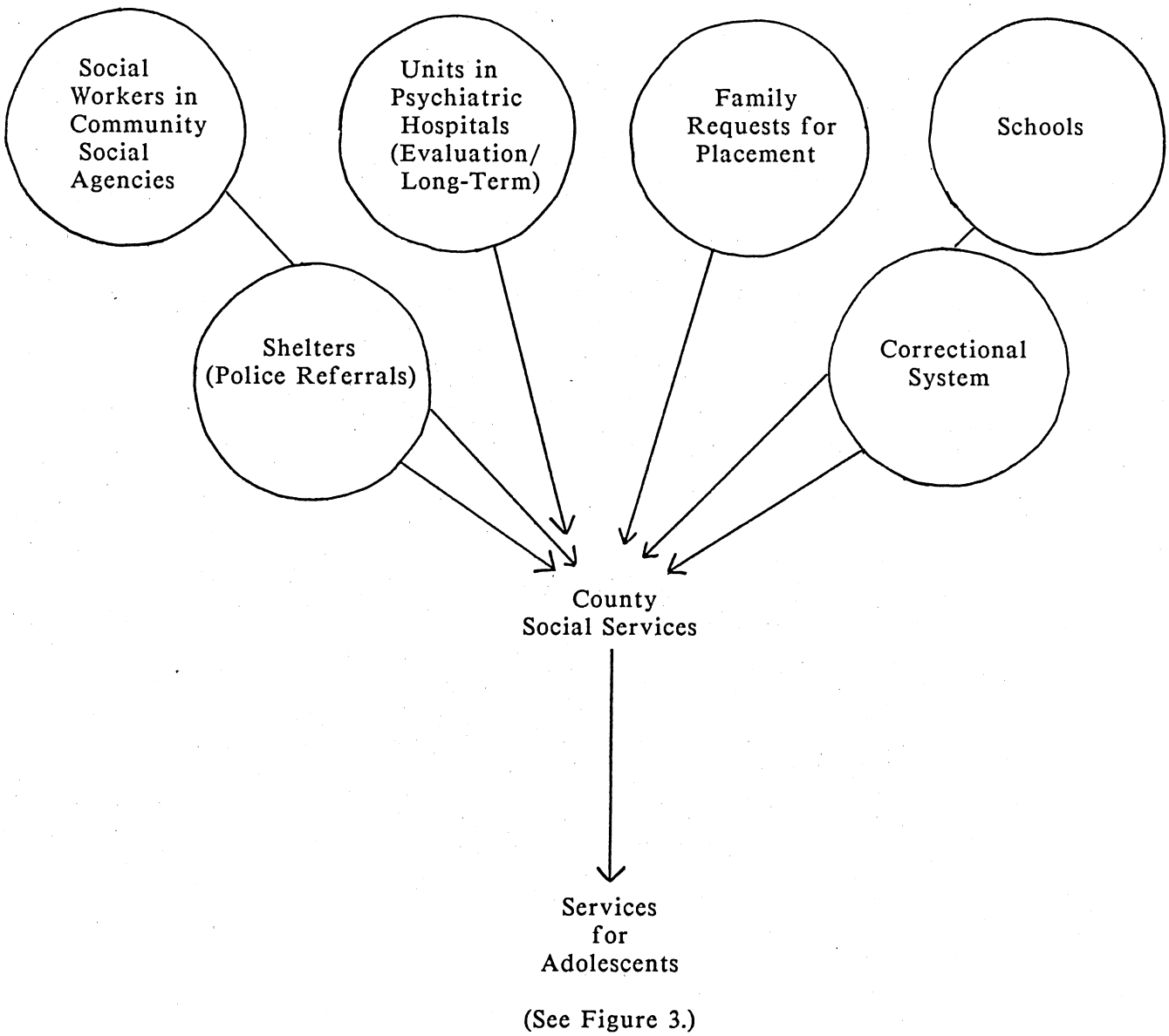
Figure 4. SERVICES FOR THE DEVELOPMENTALLY DISABLED: A CONTINUUM OF CARE*



*Data derived from "Semi-Independent Living Services (SILS)" memo from the Minnesota Department of Public Welfare, January 1982, p. 1.

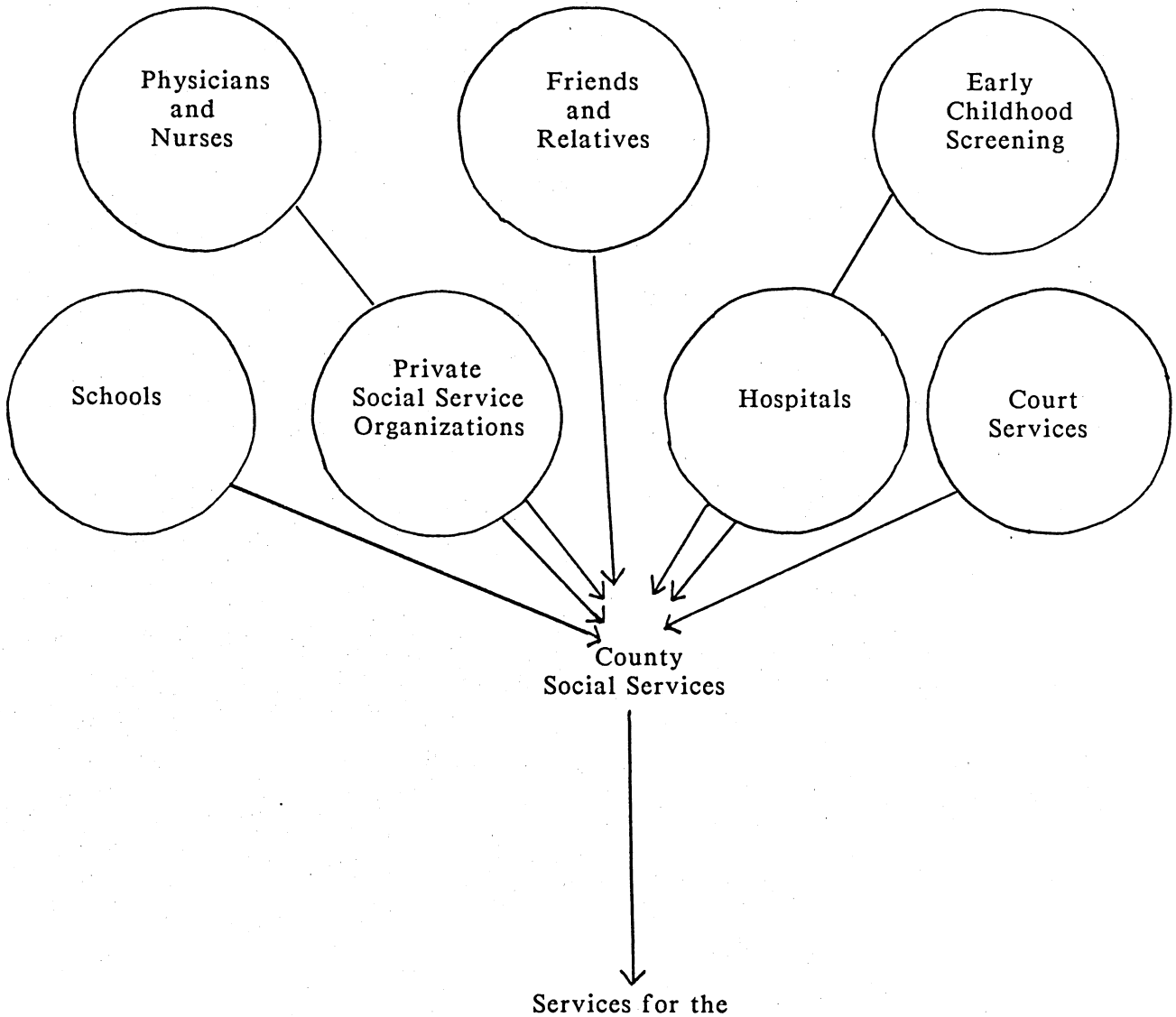
For both of these populations there are several entry points and referral may come from a number of sources, but it is the county that holds the purse strings and acts as the funnel for placement. Figures 5 and 6 delineate the referral sources for each population.

Figure 5. HOW ADOLESCENTS GET INTO THE SYSTEM: SOURCES OF REFERRALS



(See Figure 3.)

Figure 6. HOW THE DEVELOPMENTALLY DISABLED GET INTO THE SYSTEM: SOURCES OF REFERRALS



(See Figure 4.)

THE ROLE OF ADVOCACY

A number of associations have been created that represent people involved with these two vulnerable populations.

The Minnesota Council of Residential Treatment Centers (MCRTC), developed in 1969, provides peer support and review, education, and training for workers in the adolescent field. In 1970, MCRTC contracted with the Minnesota Association of Voluntary Social Services Agencies (MAVSSA) to deal with their political concerns.

A far more elaborate and politically sophisticated network of organizations exists for workers and clients in the developmentally disabled area. It includes the Minnesota DAC Association (MNDACA) for the directors of DACs; the St. Paul Association for Retarded Citizens (SPARC); the Minneapolis Association for Retarded Citizens (MN-ARC); the Parent Advocacy Coalition for Educational Rights (PACER); and the Association of Residences for the Retarded in Minnesota (ARRM).

The difference in political clout between the two populations is also evident in the presence (or lack) of advisory committees, the powerful special-interest groups that counties use as one way of providing citizen participation.[21] None were reported for the adolescent population. Indeed, the only visible advocacy was furnished by the "provider" group, those who had developed services. Investigative bodies have appeared and disappeared, leaving behind an awesome collection of reports and streams of recommendations. In contrast, advisory committees for the developmentally disabled (mentally retarded) are found in at least seventy counties across the state--80 percent of the total.

Legal advocacy for juveniles has dwindled during recent years. A remnant, in the form of an agency such as the Coalition for the Protection of Youth Rights, folded in 1982 when funding was no longer available. Legal Services Corporation will, from time to time, provide advocacy assistance for individual adolescents, but no "youth rights" advocacy organization presently exists. (A recently formed Governor's Council on Youth, 1983, is yet to make its mark as a strong advocacy agency.)

However, Legal Advocacy for Developmentally Disabled Persons in Minnesota, is officially designated by the state to protect and promote the rights of this population.

There are numerous other disparities. For example, the developmentally disabled benefit from the Developmental Disabilities Program, an official program lodged in the Human Services Division of the State Planning Agency and funded by federal and state appropriations. No comparable office or program exists for adolescents.

Client advocacy--both by clients and by relatives of clients--is a distinguishing feature of the developmentally disabled population. We found none for troubled adolescents.[22]

Finally, a fairly lucid and well-understood assessment process is in place for the developmentally disabled. It is based on degree of condition--borderline, mild, moderate, severe, and profoundly retarded. Consequently, the array of responses available for these varying conditions gives the system an understandable rationale.[23] This provides a clear position for advocacy related to needs based on condition.

For troubled adolescents, however, the assessment process is frequently characterized by conflict. Assessment varies depending on whether the adolescent is involved with the treatment-oriented child welfare system, the punishment-oriented

juvenile justice system, or both. The lack of a coherent and consistent diagnostic approach has resulted in large numbers of adolescents moving randomly though various programs and facilities at the discretion of front-line caseworkers, judges, and mental health professionals. For potential advocates, the diagnostic and treatment scene for juveniles is one of confusion.

RESIDENTIAL TREATMENT PROGRAMS FOR ADOLESCENTS

In 1981, 6,266 Minnesota children from 5,242 families were in substitute care. Of these children, 46 percent were between ages 14 and 17; the average age was 14. Forty-eight percent were in public agencies. The total cost to the state was in the area of $64 million.[24] In 1983, 5,982 youngsters were in out-of-home care at the end of the year. By 1984, the number appeared to be approximately the same. The distribution of their placements is instructive (see Table 1).

Table 1. LIVING ARRANGEMENTS OF CHILDREN IN OUT-OF-HOME CARE 1983-1984*

	1983	1984
Foster Family	3,255	3,268
Child Care Facility (Rule 34 and Rule 5)**	1,156	1,311
Group Home (Rules 8 and 34)	545	614
Emergency Shelter	330	374
Other/Runaway	333	204
Adoptive Home--not finalized	157	163
Independent Living	31	28
Other	175	320
TOTALS	5,982	6,282

*The above data were received by telephone on July 31, 1985 from Sandy Rubin, Office of Monitoring and Reporting, Social Services Division, State of Minnesota. 1984 figures are tentative pending installation of a new data system for the Department of Human Services.

**This arrangement includes approximately 800 to 900 youngsters in Rule 5 facilities. The remainder are developmentally disabled children in a child care facility licensed under Rule 34.

It should be noted that the number of children in out-of- home care has not changed substantially over the years. Further, the number of children in residential treatment centers is a small proportion of all children in care.

The adolescent treatment scene is widely regarded as a crisis-ridden milieu. Troubled youths who are referred to county social services require highly skilled intervention efforts, and their needs change rapidly and unpredictably. Consider the range of problems they present, as described in these phrases commonly found in referral statements: "defies parental authority".... "frequently runs away from home".... "on the street without family connections".... "chronically truant from school".... "hooked on drugs and/or alcohol".... "involved in prostitution".... "assaultive behavior".... "fire-setting propensities."

Increasing numbers of adolescents are brought into the system under petition by their parents for various behaviors termed "out of control"--running away, waywardness, and so on. Those between the ages of 15 and 17 are usually unwilling to be placed in foster homes, and there appears to be a growing population of youths who are totally lacking in family support and are not yet ready, either legally or psychologically, for emancipation.

Life-shaping decisions are handed down by a wide variety of systems--the public health system, the school system, the judicial system, and both the public and private sectors of the social services system--which intersect and interact in complex ways. Social workers, probation officers, and judges often distrust one another. Regulations and legalities exist, but at the same time wide discretionary powers are characteristic of the muddled systems; resulting in adolescents being treated differently due to the accident of geography or the happenstance of landing with one referral source over another.

The search for effective responses is ongoing. Minnesota offers an elaborate array of options for dealing with troubled youths, underscored by the continuum of care concept. The approximately 300 facilities that have been identified include those offering outpatient day treatment, facilities with inpatient programs for the chemically dependent, foster homes, group homes, group treatment homes, individual treatment homes, community-based residential treatment facilities,[25] private inpatient psychiatric facilities, state mental hospitals, and state correctional facilities.

Fragmentation and allegations of inappropriate placements abound. Consequently, one task force on juvenile justice has recommended that the placement of juveniles in residential programs--particularly those involved in chemical dependency treatment, which depend on third-party payments--be investigated.[26] In its report, "Out-of-Home Placement of Children: A Departmental Overview," the Department of Public Welfare has defined the lack of permanency planning, the lack of coordination, and chaotic information systems as issues that must be addressed in the child welfare system.[27] Through the Labyrinth, a report generated by the Crime Control Planning Board, concludes that no structure equipped to gather and analyze information useful to legislative decision making currently exists at the state level.[28] The Minnesota state legislature, expressing its concern about the disparate points of view on out-of-home placement, directed House Research to prepare a report which was presented to the legislature in 1983.[29] A major project known as "Rethinking Juvenile Justice" proposed that deinstitutionalization policies be broadened to take into account the interrelatedness of the juvenile justice, child welfare, and mental health systems, as well as the newly emerging chemical dependency and private-use residential systems.[30] And yet another attempt to rationalize the system is evident in the task force assembled to revise the Juvenile Code, a searching inquiry into all of the statutes relating to adolescents who might be involved in dependency, protection, deliquency, or commitment circumstances.

The 149 page report on revising the Juvenile Code was introduced into the 1985 session for legislative action but no action was taken. It was reintroduced in the 1986 session and, again, no action was taken. Hearings by a special subcommittee, Crime and Family Law, were held around the state.[31]

Unmistakably, however, the retrenchment fear as well as changing treatment orientations is forcing a severe scrutiny on the uses of residential treatment as an option for disturbed adolescents.

CHARACTERISTICS OF RESIDENTIAL TREATMENT FACILITIES

Rule 5 sets very specific guidelines for residential treatment facilities. These govern the nature of the facilities themselves, their staffing patterns, their administrative features, and their treatment programs. For example, directors must have a degree in one of the human services (many, in fact, have come from the probation/social work field), as well as a certain number of years of management experience.

At this time, there are thirty-one Rule 5 facilities in the state. In 1985, ten of these facilities were in Ramsey County and five were in Hennepin County.[32] Their locations appear to have been more or less randomly determined by historical accident and the availability of appropriate buildings. Predictably, most residents are youths from the metropolitan area.

Like other community-based facilities, Rule 5 facilities operate under varying auspices. Some are offshoots of long-established multi-service agencies such as the Wilder Foundation, Catholic Charities, Children's Home Society, Lutheran Social Services, and Volunteers of America.[33] Others are free-standing units such as The Bridge.

There is little agreement as to whether these differing arrangments provide stability. We might assume that a large, established agency could more easily reallocate staff, shift budgets, and redirect programs in order to adapt to changing circumstances, and some observers believe that this is the case. But staff have been laid off and programs eliminated within the well-established, stable organizations, as well. Still, it is generally conceded that the most vulnerable facilities are the free-standing ones which depend almost exclusively on county contracts.

SOURCES OF FUNDING

Rule 5 facilities are funded by the state Community Social Services Act (CSSA) block grant to the counties.[34] The funds that stream into the CSSA to make up this block grant come from several sources. At any given time, the grant may consist of monies from Title XX of the federal Social Security Act, IV-E of the Social Security Act (funds for children in AFDC families), or state appropriations. In combination with local funds and insurance reimbursements, the funding is jumbled together in what some term "a big black box;" resisting a clear audit trail. Ramsey County estimates that these sources may generally be broken down into 63 percent local, 19 percent federal and state, and 18 percent insurance and third-party payments.

Funding for Rule 8 facilities (small group homes with less emphasis on psychiatric treatment) is estimated at 91 percent local.[35]

Annual purchase-of-service agreements for Rule 5 facilities are negotiated on a per child/per diem rate basis. Per diem rates are based on 95 percent occupancy and varied from $70 to $85 in 1984-85.

Residential treatment facilities are among the most expensive responses in the range of options available to troubled adolescents. While they are not as costly as hospital psychiatric inpatient units or some specialized facilities that exist in the private psychiatric realm, they nevertheless take a big bite out of county budgets. The average cost per child ranges from $30,000 to $40,000 per year. In 1981, adolescent services absorbed 13 percent of the total county social service expenditures for the state of Minnesota.[36] This figure has not changed substantially over the years.

Concerns with fiscal costs were intensified by changes in treatment orientation, which was beginning to emphasize family treatment as opposed to out-of-home treatment in a residential facility.

The retrenchment period inaugurated a period of un-certainty and apprehension among providers. Indeed, in 1982-83 five residential treatment centers were closed, although one was reopened shortly after closure.[37]

To some extent, as we see in Table 2, the budget allocations in purchase-of-service agreements with Rule 5 and Rule 8 facilities reflect the sharp curtailment in use of these facilities which dominated 1982-83.

It is instructive, however, to examine per capita expenditures via purchase-of-service agreements for adolescent facilities governed by Rules 5 and 8 (see Figure 7).

Table 2. FUNDING FOR RESIDENTIAL ADOLESCENT SERVICES (RULES 5 AND 8) IN HENNEPIN AND RAMSEY COUNTIES, 1981-1985

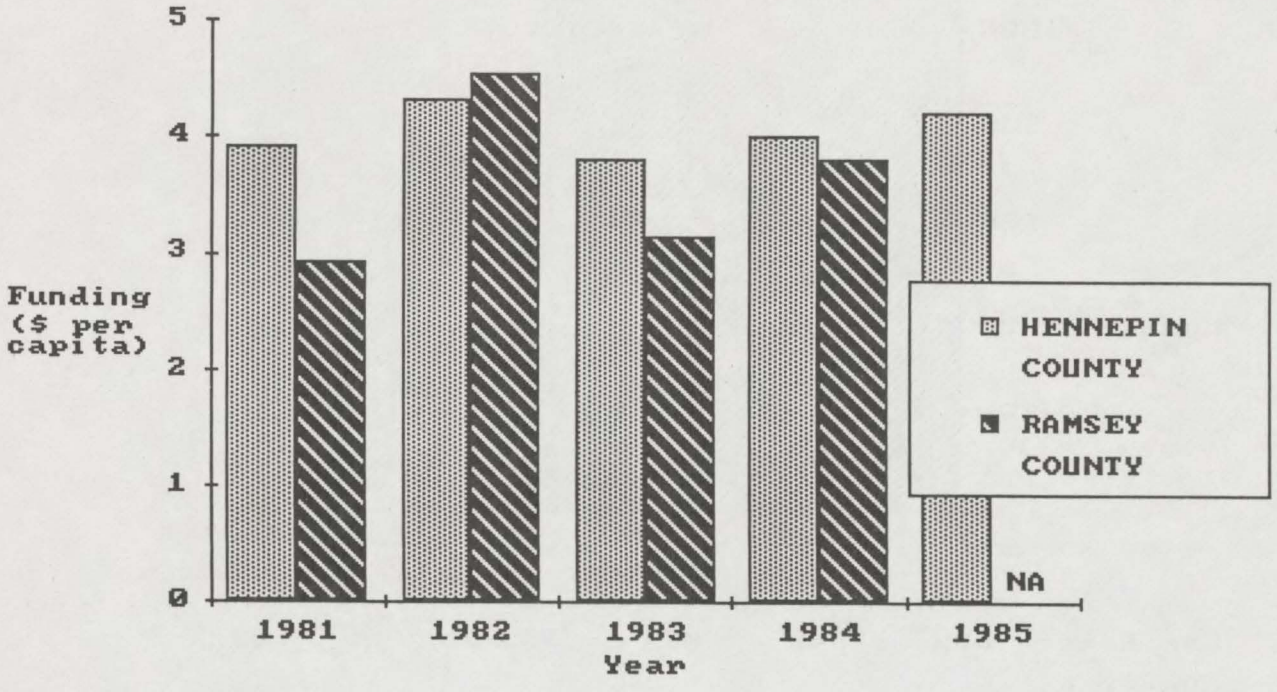
	1981	1982	1983	1984	1985
HENNEPIN COUNTY					
Rule 5 (N=2)	$ 786,085	$ 852,377	$ 747,056	$ 764,842	$ 801,678
Rule 8 (N=12,9))*	2,909,653	3,207,808	2,828,720	3,001,540	3,166,467
TOTALS	$3,695,738	$4,060,185	$3,575,776	$3,766,382	$3,968,145
Per Capita:					
Rule 5	$ .84	$ .91	$ .79	$ .81	$ .85
Rule 8	3.09	3.41	3.00	3.19	3.36
TOTALS PER CAPITA	$3.93	$4.31	$3.80	$4.00	$4.22
RAMSEY COUNTY					
Rule 5 (N=13,8)**	$1,314,279	$1,980,274	$1,259,026	$1,654,985	NA
Rule 8 (N=3)	29,973	112,380	186,258	93,297	NA
TOTALS	$1,344,252	$2,092,654	$1,445,284	$1,748,282	NA
Per Capita:					
Rule 5	$2.86	$4.31	$2.74	$3.60	NA
Rule 8	.07	.24	.41	.20	NA
TOTALS PER CAPITA	$2.92	$4.55	$3.15	$3.14	NA

NOTE: Per capita expenditures are based on population figures from the 1980 census.

* One facility in Hennepin County, funded at about $202,200 in 1981 and $221,600 in 1982, was not funded in 1983, 1984 or 1985. Another, funded at about $162,900 in 1981 and $178,900 in 1982, closed in 1983. Thus, figures for 1983, 1984 and 1985 are based on funding by the county of nine Rule 8 facilities rather than eleven. See Appendix G for specific facilities closed or otherwise not funded.

** Again, some facilities were funded some years but not others. See Appendix G for listing of individual facilities, years funded, and funding amounts.

Figure 7. FUNDING FOR RESIDENTIAL ADOLESCENT SERVICES.



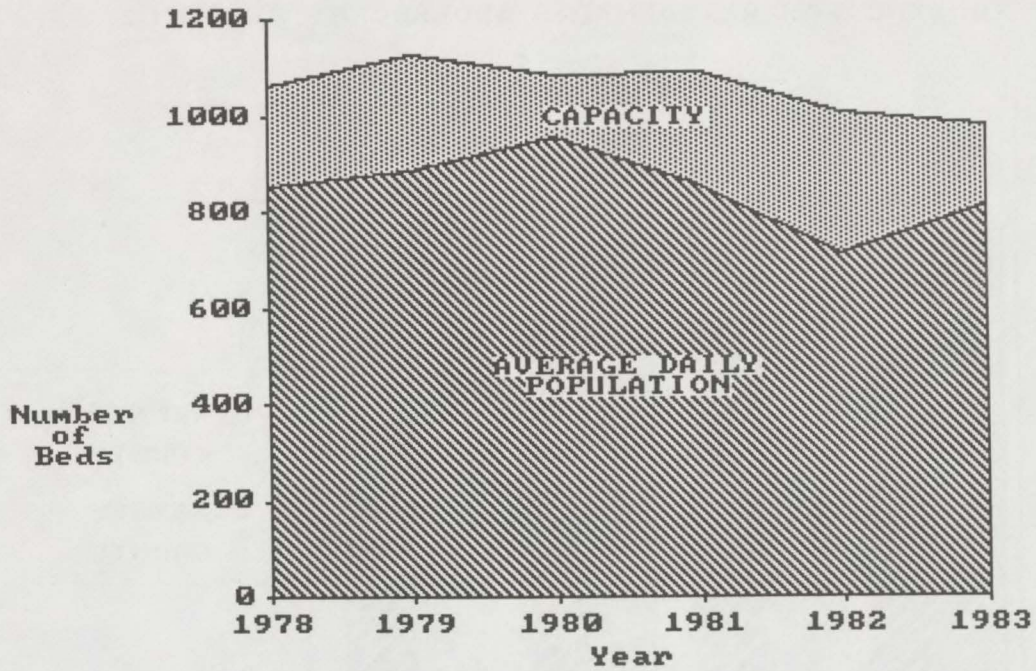
Despite the stern containment measures to reduce placements and close facilities instituted for 1981-83, expenditures in both counties crept up and, indeed, have surpassed 1981 levels. At the same time, examining the capacity and utilization rate, we see fluctuations within narrow ranges, except for the downward plunge in 1981-82 (see Figure 8).

Overall, there has been a 13.4 percent reduction in the number of beds from 1979 to 1984 (from 1,128 to 977),[38] but at the same time there has been an upsurge in emergency shelter placements.[39]

Glancing at the preceding data, a striking fact emerges. There appears to be an irreducible number of young children and adolescents for whom out-of-home care is necessary. This tends to lend credence to the frequently articulated observation of residential treatment directors: "You can put kids on ice, now and again, trying to keep them out of the system, but sooner or later they reappear, and the only alternative left after everything else has been tried is a residential treatment center." According to the residential treatment center directors who are, for the most part, intimately involved in treatment plans within their facilities, many of the adolescents currently entering Rule 5 facilities are victimized by delayed treatment. A portion of our respondents reported that referrals were often "too tough to handle."

Shifts in funding are a pervasive factor in the annual negotiations in purchase-of-service agreements. Even relatively small budget changes have an impact on programs, and the scramble to make up for lost dollars is a crucial concern for directors of residential centers.

Figure 8. CAPACITY AND USE OF RULE 5 FACILITIES, 1978-1984.



Use Rate	83%	84%	88%	78%	73%	83%
Number of Licensed Facilities	30%	32%	34%	33%	33%	33%

Source: This graph, courtesy of David J. Mayer, Director, Residential/Day Programs, Amherst H. Wilder Foundation. was based on data from the Reporting and Monitoring Unit, Department of Human Services, State of Minnesota.

It is instructive to view the annual changes in purchase-of-service agreements from the vantage point of a Rule 5 facility. The Wilder-Bush and Annex facility is a good case in point.

This facility operates under the umbrella of the well established Division of Services to Children and Families of the Wilder Foundation in St. Paul. Licensed under Rule 5, the facility is intended for emotionally disturbed youngsters, male and female, between the ages of 6 and 14. Presently, there are forty-four youngsters in treatment at approximately $27,000 per child (the per diem rate is roughly $85).

As we see in Table 3, county dollars are the chief source of funding. While Ramsey is the "host" county, Hennepin and other counties in the state also place children there. In this instance, as we see, when county dollars go down, the Wilder Foundation's dollars attempt to replace them. Client fees are continually sought but despite some increase from 1984 to 1985, this is a thin stream of financial support for the facility. The youngsters placed in this facility are from families, generally, that are detached from health insurance plans or that are under the protection of the county.

Table 3. FUNDING SOURCES FOR WILDER-BUSCH AND ANNEX, A RULE 5 FACILITY

	County Dollars	Client Fees	Wilder Foundation Subsidy
1981	$ 908,749	$17,907	$ 99,167
1982	1,018,711	---	148,370
1983	853,370	---	234,039
1984	1,215,714	10,000	58,791
1985	1,281,936	20,500	35,248

Of course, the cushion provided by Wilder Foundation is not available to facilities that are independent. Their absorption of annual budget changes and the impact of these changes on programs have not yet been studied.

THE POLITICS OF PLACEMENT DECISIONS FOR ADOLESCENTS

Disentangling the intricate network of factors that surrounds the questions of whom to place, when to place, where to place, and how long to place is not an easy task. It is widely understood that placement is determined internally by the social worker ("worker preference") and externally by an indirect mandate influenced by the cost of care and the county's fiscal resources ("accountant preference").

In most counties, "worker preference" is subjected to several layers of scrutiny. Front-line workers must consult with their supervisors, who frequently use a "screening team." Hennepin County has a placement coordinator who reviews all placement requests, as well as a screening team.

An invisible but powerful determining factor is the informal understanding that exists among workers concerning the reputations of the various facilities. Based on this understanding, one facility may be chosen over another even if the two appear to be comparable.

External pressures may also come into play, including court orders, which supersede child welfare decisions and sometimes conflict with them. Increasing numbers of parents are requesting assistance, in part because of the availability of third-party payments.[40] School systems may also make recommendations.

It is the county, however, which pays the bill and casts the final vote. While the degree of importance attached to "accountant preference" may vary from county to county, it is generally given a good deal of weight in placement decisions. For example, length of stay is chiefly determined by fiscal concerns. In Ramsey County, six months is the limit currently permitted for Rule 5 facilities; four months for Rule 8 facilities; and one year for foster homes. These limits may be extended on petition. Hennepin County is not as explicit, but its social services "environment" prefers intensive services to families as alternatives to placement. Hennepin, Ramsey, and Dakota counties have developed special units to provide such services.

In recent years, out-of-home placement rates seem to be riding a roller-coaster. In Hennepin County, 554 requests for placement were made in 1981. In 1982, this figure dropped by 40 percent, but by 1983 requests were back to 1981 levels. There is no clear explanation for this phenomenon, but the most widely held "off-the-cuff" opinion offered is that the alternatives tried in 1982 had become "unglued."

For certain adolescents, placement in Rule 5 facilities appears to be a necessity. (One adolescent with a history of sexually molesting young children has been in four foster homes and one group setting, each of which has failed.) A dominant impression formed during interviews with Rule 5 directors was that due to the short-term economy, a number of youths had been placed inappropriately in facilities not equipped to deal with them. Many directors predict that the community will pay later for this "benign neglect."

Meanwhile, they maintain Rule 5 is serving as the "dumping grounds" for the failures of the rest of the system. Some counties now demand proof of failed placement in other facilities before accepting a Rule 5 placement. According to the directors we spoke with, many adolescents being referred for treatment have a record of five to six previous placements in foster and group homes. "Treatment-jaded" youngsters and their "treatment-jaded" parents are coming to Rule 5 facilities after having been "bounced around" elsewhere; "multiple failures" and "multiple placements" are common.

Evidence for this observation is contained in information that shows that of 697 youngsters in Rule 5 facilities as of July 1985, more than 60 percent had come from a previous placement, such as foster homes, in-patient hospital psychiatric units, shelters, and detention facilities.[41]

THE CURRENT ENVIRONMENT

Closures, restrictions, reductions in placements, increased monitoring, changing uses of other alternatives in the out-of-home placement system have produced a highly volatile state for residential treatment centers. Nevertheless, the "survivors" of the 1981-83 turbulence have stated they are now on solid ground. They have diversified their funding sources and intensified their outreach; some have developed new services. It is clearly understood that a heavy reliance on any one county is risky. Having weathered the fiscal storm of 1981-83, their chief concern now is to maintain the integrity of programs designed for seriously disturbed youngsters and to resist manipulations that may be "accountant driven."

QUESTIONS ABOUT THE FUTURE

The live-or-die crisis of the first retrenchment shock has subsided, but hard questions remain. Strong critics are leaning on the providers of services to seriously disturbed youngsters to provide proof of effectiveness of treatment of high cost residential care. The charge is: inappropriate admissions. Counties are perplexed by the fact that despite the numerous changes and restrictions in out-of-home placements, the budgets remain the same, if not higher, from year to year.

Attacks and counter-attacks deal chiefly with "numbers." Strikingly missing from the exchanges is evaluative data on treatment effectiveness. Knowledge derived from rigorous clinical studies is almost nonexistent. Long term follow-up studies of this vulnerable client group are lacking.

Long term treatment is being supplanted by short-term care. Ramsey County's six month limitation makes this clear. What will happen to adolescents who truly need long term treatment? Will adolescents in need of treatment be discharged into unstable, unsafe home environments?

The system is characterized by random movement in and out of various programs and facilities. Since there is no consensus on how to respond to a group of adolescents who are vaguely referred to as "seriously troubled," no agreement exists on the specific role of residential treatment facilities.

The assumption is taking hold that a Rule 5 facility should be a final step, a last stop; that placement in such a facility early in an adolescent's life-cycle of disturbance is inappro-priate.

What is the pragmatic basis of this judgment? For what group of adolescents and under what conditions is residential treatment appropriate? Is there sufficient clinical evidence on treatment outcomes for counties to monitor the effectiveness of the programs in their contracted purchase-of-service agreements?

There are some developments, however, chiefly of a basic information nature. The emergence of a tracking system that enables us to have a clearer picture of the duration and location of placements and treatment outcomes is being developed by the Department of Human Services.[42] The Minnesota Council of Residential Treatment Centers is initiating its own information system. Ramsey County has instituted an evaluation and monitoring system, and Hennepin County is engaged in a strategic planning process. Moreover, review boards, screening committees, and placement coordinators are now engaged in scrutinizing placement decisions.

However, few informants are satisfied. The cracks in the system of accountability are sometimes deep. Who is responsible for shaping and reshaping the array of options for emotionally disturbed adolescents? Who is accountable for a history of failed placements and an end-of-the-road despair that character-izes the outcomes of a large number of adolescents requiring Rule 5 out-of-home placements? Who will fund clinically controlled experiments and long term follow-up studies to provide basic knowledge on treatment outcomes?

DEVELOPMENTAL ACHIEVEMENT CENTERS (DACS)

The Community Social Services Act of 1979[43] gave counties wide discretionary powers when it came to deciding what services to offer. Soon, however, a shift in funding sources and important new judicial decrees began intruding on local decision-making processes. Nowhere were the effects of these external forces felt more strongly than in Developmental Achievement Centers (DACs), community-based facilities for the mentally retarded. DACs serve, primarily, a population of adults from the age of 22 on. (They may serve pre-school children, although there is no mandate for this. School age children are chiefly absorbed in the school system through the legislatively authorized process of "mainstreaming.") DACs provide skill development which is intended to prepare persons for living in the community. Programs typically include preparation for work, socialization and daily living skills such as personal hygiene and money management. If persons are living in residential centers they must leave during the day to participate in a day-care program such as that offered in a DAC. In other words, residential programs and DACs are linked.

A brief history is instructive. Prior to 1960, few DACs existed in Minnesota. The 1960s and 1970s were a boom period; federal dollars became available through Titles IVa and XX of the Social Security Act, and state appropriations were also made. By 1978, the state had 104 DACs serving 4,220 clients at an annual cost of $15 million.[44]

Minnesota appeared to lead the nation in the rapid establishment of these activity centers. The guiding philosophy was described in a 1972 report of the President's Committee on Mental Retardation:

> The severely mentally retarded have a potential and are entitled as human beings in our society to have their potential developed to capacity. It is the responsibility of society to develop and make maximum use of their potential.[45]

The deinstitutionalization movement of the 1970s further accelerated the growth of DACs, as noted in a 1980 journal article:

> Today these programs represent a significant element of each state's adult service planning and have become critical in efforts to disperse residents of public institutions into community programs. Adaptive day programs frequently are viewed as providing the initial services for newly deinstitutionalized individuals... [46]

According to this report, even more DACs were needed than existed at the time, since "placement of individuals out of institutions frequently (was) contingent on availability of space in adaptive day programs."

By 1980, 106 DACs existed statewide and the amount of public dollars for running them began to increase (see Table 4).

Table 4. SOURCES OF REVENUE FOR MINNESOTA DACs, 1980-82*

Year	Government	%	Family	%	Other**	%	Total
1980 (N=106)	$21,566,315	94.2	$401,072	1.8	$922,690	4.0	$22,890,077
1981 (N=106)	24,650,217	94.9	454,509	1.7	872,062	3.4	25,976,788
1982*** (N=105)	25,960,897	94.9	513,873	1.9	886,083	3.2	27,360,853

*Totals are statewide with 100 percent of 106 reporting in 1980 and 1981.

**For example: fundraising, United Way, donations from philanthropic organizations, and income from work projects.

***Projected. At the time of this report, these were the last available data.

SOURCE: The Financial Status of Minnesota Development Achievment Centers: 1980-1982. Policy Analysis Series: Issues related to the Welsch Consent Decree, Paper No. 6, St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January 1982, p. 5.

RESPONSES TO BUDGET CONCERNS

The crisis of 1981 resulted in admission policy changes being effected for that year and anticipated for the next. These varied widely from region to region across the state and from DAC to DAC.[47] For example, some counties discontinued their infant and preschool programs, while others emphasized eligibility preference for more severely handicapped children. In the area of adult admissions, "capacity to benefit" became a closely scrutinized item. Alternative placements, reduction of out-of-county placements, and cutbacks in service days were other scattered responses. A summary of policy changes is found in Appendix D.

In 1981, DACs absorbed 9 percent of the total county social service expenditures in the state of Minnesota, amounting to almost 25 million dollars.[48] But the sharp decline in funding in the first phase of the retrenchment era, 1981-82, sent shock waves through Ramsey County and anxiety throughout the DAC purchase-of-service sector in Hennepin County.

Once again, the two contiguous urban counties reacted differently. Hennepin County during 1981-82 maintained and even increased its expenditures for DACs slightly, while Ramsey sharply cut its adult facilities and drastically curtailed expenditures for pre-school. By 1983, as we see in Table 5, Hennepin continued its increase slightly and Ramsey, in a roller coaster effect, pumped substantial amounts of money into DACs; bringing levels even higher than 1981. However, in 1984 with new dollars from the Medicaid program a considerable drop in purchase-of-service agreements occurred, as noted later (see page 53).

An external event (a judicial decree, as we shall see later) had influenced budget allocations as well as a newly discovered source of money (the Medicaid program). While substantial cuts occurred in the 1981-82 crunch, only one DAC was closed in Ramsey County (see Table 6). Most DACs absorbed the cuts by shrinking their staffs. (During 1981-82, adults accounted for 73 percent of the total DAC population. The school-age population is, and remains, the smallest--2.6 percent--since it is primarily served by the public school system.[49]) Significantly, more than one-third of the DACs had waiting lists in 1981. Seventy-one infants, 75 pre-schoolers, and 302 adults had not yet gained admission to programs.[50]

Table 5. CHANGES IN DAC PURCHASE-OF-SERVICE AGREEMENTS, WITH HENNEPIN AND RAMSEY COUNTIES, 1981-84

	1981	1982	1983	1984
HENNEPIN COUNTY				
Children	$2,004,789	$2,188,406	$2,416,807	$2,546,301
Adults	2,927,297	3,839,684	3,826,656	1,611,742
TOTALS	$4,932,086	$6,028,090	$6,243,463	$4,158,043
RAMSEY COUNTY				
Children	$1,029,000	$ 676,000	$ 753,000	$ 874,000
Adults	1,718,000	1,318,000	2,097,000	796,000
TOTALS	$2,747,000	$1,994,000	$2,850,000	$1,670,000

SOURCE: Hennepin County data are from the Community Services Department, Purchase of Service Office, Hennepin County. Ramsey County data are from the Community Services Department, Ramsey County.

Table 6. CHANGES IN RAMSEY COUNTY FUNDING PATTERNS FOR DACs, 1981-1983

Category/Agency	FY 1981	FY 1982	Calendar Year 1983	Percent Change 81-82	Percent Change 82-83
ADULT DACs					
Greenhaven Heights	$234,922	$191,002	$267,667	-19	+40
Kaposia	90,271	115,287	202,071	+28	+75
Merriam Park	154,697	125,225	222,920	-19	+78
Merrick	156,341	129,013	235,455	-17	+83
PRESCHOOL DACs					
Kaposia*	94,248	17,395	--	--	--
St. Paul's DAC (St. Paul's on the Hill)	205,995	137,776	218,243	-33	+58
St. Paul's Rehab. Ctr.	250,958	196,263	236,111	-22	+20
St. Paul's DAC (Home-bound)	110,990	95,519	117,466	-14	+23

*Program discontinued in FY 1982; emphasis placed on the adult program.

SOURCE: Purchase-of-Service Office, Ramsey County.

A 1982 survey showed that several activities had been cut back or dropped due to budget considerations. These included sensory motor activities for infants and preschoolers; academ-ics, communication, independent living skills activities for adults; as well as self-care activities, meal service, and transportation and leisure/recreation activities. Also down were days of service and numbers of teachers' aides.

Comments from DAC providers during the spring of 1982, when interviews for this survey were carried out, revealed the mood of the time:

> "The case of a mentally retarded woman with behavioral problems is illustrative. She would be best served in a behavioral achievement center for six months to one year, and eventually would become employed. Her county refused to pay for special programs. (Funds were requested) for five days per week. County will only pay for two days per week. It will take her much longer to attain an employable level, actually costing more in the long run because treatment time would be decreased if she could be in a concentrated program."
>
> "We may be on the verge of reinstitutionalizing and warehousing people rather than involving them. Support cuts make it extremely difficult for the independent program participants to function adequately. If things keep moving in the direction that they are currently, we will see a dismantling of years of progress in MR programs, as in others, with an emphasis on 'only the strong survive' with increas-ed institutionalization. Private corporations cannot or will not finance programs as adequately as they should be financed or even at the level which is currently the situation."
>
> "Because of the rise in MTC fares, transportation is hindered and limited"..."Special education service in public schools are being cut back"..."The Division of Vocational Rehabilitation is lacking funds, so money for work training is severely cut and persons are eliminated from the program"..."Movement into the community and labor force by the handicapped will become extremely difficult if not impossible".... "Counties are a 'battleground' for human service funds"..."Clients are being denied their rights. Eventually, many of them will have to return to state hospitals because they will have nowhere to go..."
>
> "We are moving backwards!"[51]

But as counties grappled with rising expenditures for DACs--and the growing concern that they were absorbing more than their fair share of the social service dollar--events were occurring on the outside that would affect their decision-making in ways they could not have forseen.

THE WELSCH V. NOOT DECREE

Lengthy litigation involving the mentally retarded persons in Minnesota's state hospitals, which began in 1978, reached a turning point on September 15, 1980. On that date, United States District Judge Earl Larson signed a consent decree which was to have a significant impact on the delivery of services to the developmentally disabled, both in state institutions and in the community.

As approved by the court, the forty-page Welsch v. Noot decree contained unusually specific provisions detailing three fundamental requirements:

1. The population of mentally retarded persons in state institutions would be substantially reduced.

2. The existing allocation of staff for mentally retarded residents could not be reduced until staffing standards laid out in the decree had been met.

3. Individual rights of the mentally retarded would be protected.

The third requirement included provisions covering everything from the need to provide wheelchairs to limitations on the use of restraints and seclusion. It even outlined how major tranquilizers are and are not to be used.

It was the first requirement, however, that made all the difference to DACs. If the institutionalized mentally retarded population was in fact to be reduced, then DACs would clearly play a pivotal role.

According to the decree, mentally retarded persons may be admitted to state institutions only when no appropriate community placement is available. Furthermore, appropriate community placement must be located or developed so that no child will reside at a state hospital for longer than a year.

The movement of an individual out of a state institution and into community placement must now be carefully planned. The actual needs of the resident, the discharge plans, and the daytime services available to him or her must all be assessed. And preference must be given to small facilities with popula-tions of sixteen or fewer.

The consent decree also provided for the establishment of compliance reports, reporting procedures, and obligations imposed on the state through regulation.

The implementation of Welsch v. Noot will be monitored until July 1, 1987. At that time, the jurisdiction of the court will end if the defendants have substantially complied with the terms of the decree.[52]

Predictably, this decree has stimulated an accelerated development of community-based services across the state. The primary responsibility for community-based placements rests with the county.

THE 1983 SUPREME COURT DECISION

In January of 1983, the Supreme Court of Minnesota declared that counties must provide mentally retarded persons with a level of DAC services consistent with their needs. In effect, counties may no longer arbitrarily reduce the levels of manda-tory DAC services from those recommended by individual service plans.

The case in point involved a challenge by seven develop-mentally disabled individuals who were receiving DAC services to an October 1980 decision of the Kittson County Board to reduce their level of services from five days a week to three. The board had taken this action in response to certain budgetary limitations without first assessing the needs of the clients.[53]

The Supreme Court opinion overturned an April 1981 decision, upheld earlier by the Ninth Judicial District, which permitted counties to limit the provision of services in

response to certain serious fiscal constraints.

Three issues were in dispute:

- the effect of state agency rules (particularly Rule 160, which governs administration of the CSSA and mandates a list of services including DACs);
- the authority of counties under CSSA to supersede such rules; and
- the definition of what constitutes monies that are "available" to pay for services.

Speaking to the first issue, the court observed that Rule 160 had been promulgated "to ensure that county boards would follow established state priorities in allocating their funds among diverse disabled persons." The designation of DAC services as mandatory "recognizes both the high priority the state has placed on the deinstitutionalization of the mentally retarded in Minnesota and the requirements of the Welsch Consent Decree."

The court noted that Kittson County could have reevaluated the individual service plans of its clients to see whether their DAC services could be reduced. If it found that they could not, the county could have reallocated funds from optional priority areas. Its decision to ignore these options and instead to impose across-the-board cuts without regard to need conflicted with the mandates of Rule 160, according to the court.

In their arguments before the court, Kittson County and Public Welfare Commissioner Arthur Noot contended that counties could limit what they spent on DAC services to the funds appropriated for that purpose. In her opinion, Justice Rosalie Wahl pointed out that interpreting the rule and statute in this way "would permit counties to budget insufficient funds and then terminate or limit mandatory services arbitrarily." She declared that all state, federal, and local funds counties received for social services were actually "available" to pay for DAC services.

Since for Kittson County this total amounted to almost three times what it was spending for DAC services, the court found that funds were "available" for this purpose and were, therefore, to be used for it.

"MEDICAIDING" THE SYSTEM

Under Chapter 312 of the 1983 Minnesota Session Law, a Title XIX (Medicaid) waiver bill was passed by the legislature. This bill, which mandates that Minnesota Department of Public Welfare apply for a waiver to Health and Human Services,[54] sets a new direction for delivery of services to developmentally disabled persons.

The principal purpose of this "Home and Community-Based Care" waiver is to contain costs by encouraging alternatives to expensive institutional care. It is meant to hold down the number and costs of care of intermediate care facilities (ICF/MRs)[55] as well as state institutions. It is also intended to eliminate the inappropriate placements of developmentally disabled persons in ICF/MRs. Finally, it should result in substantial savings for the state--savings up to $21 million annually, according to some estimates--by shifting part of the burden of funding DACs away from CSSA to Medicaid.

Within the array of alternatives to be developed, DACs would remain as prominent options, but creative new approaches to daytime programs would also be

encouraged. At the county level, screening teams would decide appropriate care and services for each application. The state, through the Department of Public Welfare, would set rates and authorize payment.[56]

A complex set of regulations to control inappropriate placements and services and to monitor placements had been put into place. The shift in funding responsibility, effective January 1, 1984, called for CSSA to match the Medicaid dollars (which will be somewhere in the area of 50 percent federal), thereby offsetting some of the local savings.

In any event, the strong, steady stream of federal dollars in what became known as "Medicaiding the system" was intended to stabilize funding for the DACs.

1985 UPDATE

The period of stability did not last long. For the DACs, signals of distress began to appear from several sources.

First, a change in treatment emphasis emerged. Vocational training and on-the-job training were becoming the preferred focus. With work as a primary emphasis, metropolitan counties began to explore alternative options to the DACs for this effort. At the same time, clarifications in definitions and rules were shaking up DACs. "Working," "therapeutic work activity," "habilitation," were being defined in ways which generated controversy. Reimbursement by Medicaid dollars for "therapeutic work activity" was undergoing a challenge by the federal government. Further, the state's proposed rule for reimbursement is undergoing some changes.[57] Moreover, proposed changes in Rule 160, which governs the administration of CSSA funds, has profoundly upset the community of DAC providers. A brief account of the background of the rule change is in order.

The 1985 state legislature reinforced its interest in preserving and expanding the local control features of CSSA, which gives counties wide discretion in how to spend their social service dollars. In that light, the state Human Services Department was encouraged to provide changes in Rule 160 consis-tent with increasing local autonomy. Reflecting legislative intent, the list of specific mandated services, which included DACs, was eliminated. Despite intense lobbying on the issue, the change was proposed (and some 200 pages of testimony, most in opposition to the proposed rule change, were gathered).

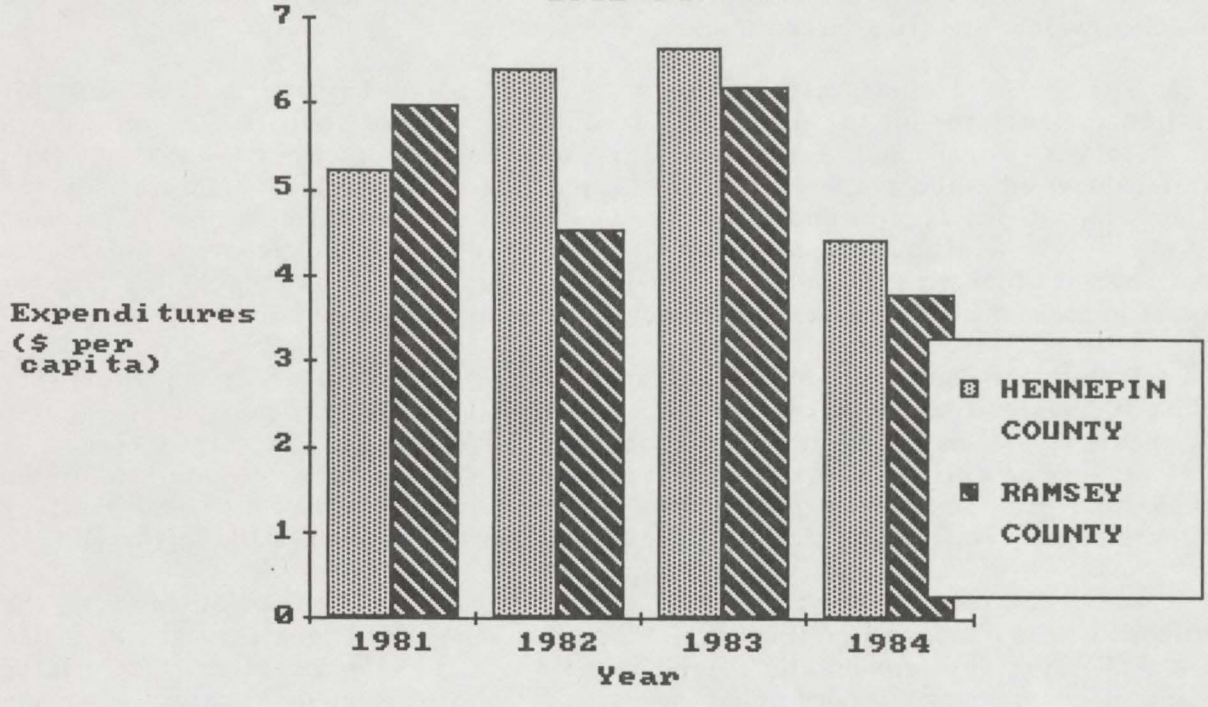
The elimination of mandated services was interpreted by many DAC providers as an action that stripped the mentally retarded population of its "protected" constituency status which had been guaranteed by judicial decisions. Not so, asserted state Human Services spokespersons: the rule change will not result in loss of services since individual plans based on need will still be required. Monitoring and appeal procedures are expected to curb inappropriate cuts in services. The final out-come of hearings on the rule change by an administrative law judge is yet to be determined.

Finally, continuing budget constraints at the county level also contribute a fair share of instability. Forty to forty-five percent of clients of DACs are not Medicaid-eligible but depend on county dollars alone for their DAC service support. These persons live in foster homes, nursing homes, board and lodging facilities, and about 26 percent live in their own or adoptive homes. County dollars come via a negotiated per diem rate determined by a complex of factors such as the medical assistance reimbursement rate, the regional average rates, and the consumer price index. Although rates may be reviewed for a special needs population, such as a developmentally disabled

group with profound behavior disorders, generally county rates are considered barely adequate. The current average per diem in the state is $29.38. However, variations exist within regions. For example, Ramsey County, through its own budget austerities, has had to set a rate that is significantly lower than Hennepin County's. The negotiated rate is a stern reminder of the "down to the bone" syndrome and affects a significant portion of the DAC population.

As we see from Figure 9, both counties from 1981-83 spent substantial dollars per capita for DACs. By 1984, the advent of Medicaid dollars brought a significant drop to the purchase-of-service expenditures. Whether or not the deletion of DACs as a mandatory service will bring further changes in budget allocations remains to be seen.

Figure 9. PURCHASE-OF-SERVICE EXPENDITURES FOR SERVICES TO THE MENTALLY RETARDED IN HENNEPIN AND RAMSEY COUNTIES, 1981-84.



In summary, at mid-decade DACs, a major component in the purchase-of-service arena, now face several challenges.

Counties may choose to maintain DACs, modify their services, diminish their role, or eliminate them altogether. The counties possess all these options under the purchase-of-service agreements.

The system is in dynamic change, but despite the turbulence the field of providers remains stable. No external evidence appears for the closing of any DACs. In the words of one of the directors, "We're all hanging in there." How clients will fare under the pervasive changes is a study yet to be initiated.

COMPARISONS

Community-based facilities for disturbed adolescents requiring complex treatment plans are struggling for survival. This is due to a combination of factors, most notably the declining adolescent population, a sharp program shift from out-of-home placement to intensive work with families, and fiscal restraints which necessitated curbing the expenditures for out-of-home placements.

DACs, on the other hand, despite changes in rules, definitions and reimbursement rates, are relatively stable given that the courts have ordered an accelerated deinstitutionalization of the mentally retarded, and that new sources of funding under Title XIX have become available.

As discussed earlier, the systems serving adolescents and the developmentally disabled provide a range of options under a "continuum of care" concept. Dollar allocations for purchase-of-service agreements for each constituency, however, have been subject to widely differing circumstances.

For the developmentally disabled, court decisions have set a framework of detailed instructions on the provision of community-based facilities; a well-known classification system exists for identifying the condition of client groups; but most significantly, an elaborate and politically sophisticated network of organizations and offices exists at the federal and state level to support local advocacy groups of workers and clients. In addition to a new flow of money from Medicaid dollars, a substantial grant from the McKnight Foundation contributed almost $5 million from 1981 to 1984 for general improvement of services for the developmentally disabled.[58]

In contrast, the vulnerable adolescent clientele is subject to a fragmented delivery system characterized by placement decisions that have the appearance of random movements in and out of child welfare, juvenile corrections, and a variety of out-of-home placement options. Most significant, except for the survival interests of the service providers, and a scattering of professional human service policy and planning groups, advocacy for the adolescents either by families or friends is strikingly absent.

Indirect pressures exist that may change purchase-of-service agreements, the availability of dollars, and political preferences for certain disadvantaged groups in the future. For the developmentally disabled, there is a growing awareness that a large portion of county social service dollars (ranging from 16 percent to 30 percent) is being absorbed by this group. The question of political "taste" for this vulnerable constituency over others in the competition for funding under a block grant system is being faced at local levels of government with varying outcomes. For the adolescent group, the high cost of out-of-home placement in treatment facilities means that reimbursement patterns increasingly hold the upper hand over clinical decisions. There is an absence of earmarked money available in either public or private funds for this group.[59]

PART IV: CONCLUSIONS

BUDGET DECISIONS AT A TIME OF RETRENCHMENT: COUNTY PERSPECTIVE

Factors in the appearance, disappearance, and re-appearance of those facilities in the community-based system which rely heavily on purchase-of-service agreements require a case-by-case analysis. However, generally, the allocation of dwindling public dollars among the vulnerable constituencies served by these facilities appears to be governed by five major influ-ences.

1. Cost containment initiatives which dominate the system result in a widely understood dictum: reimbursement patterns influence treatment decisions.

2. The availability of local dollars raised by property taxes at the county level: this stream of dollars, varying from county to county, flows into the "black box" of a CSSA block grant system, which is also fed by federal and state streams. The local availability of dollars plays a decisive role in constructing budgets for purchase-of-service agreements. Illustratively, Hennepin County managed to sustain a budget more or less at a hold-the-line level, even increasing it somewhat from 1981-1985, while Ramsey's budget plunged dramatically downward in the 1981-82 fiscal crunch, and for many community-based facilities purchase-of-service agreements have not yet fully recovered. This reflects differences in the county capacity or willingness to raise dollars from property taxes.

3. External events providing a framework for budget deci-sions: court decisions mandating deinstitutionalization for a particular constituency; philosophical shifts to in-home services as a preferred treatment plan; federal and state mandates for services; standards mandated by licensing provisions; changing demography; and the infusion of special grant money, may all influence allocation of dollars among competing community-based facilities.

4. Local authorities expressing their own "taste" in pre-ferring to allocate dollars for certain constituencies over others: wide variations occur in a state such as Minnesota, which through its Community Social Services Act has given each county authority to re-allocate dollars from one service to another and from one provider to another (mentally retarded pre-school children may outrank disabled adults in some counties; whereas in others, emotionally disturbed adolescents may be treated to benign neglect).

5. Political pressures from advocacy groups and providers leaning on elected county officials, along with political "sensitivity" to community preferences provide a contextual basis for the role of politics in protecting certain community-based facilities even in a time of severe retrenchment.

These factors are interactive; consequently sorting out the tangled skein of decision-making is not easy. However, it is generally agreed that under the CSSA, which ties social service funding to elected county commissioners, purchase-of-service contracts operate in a politically charged environment.[60] Despite political pressures, almost 80 percent of county commissioners wished to retain local decision-making as provided under CSSA,[61] while human service organizations, representing, to a large degree, provider groups, felt that local governments should not be primarily responsible for decisions on allocating social service funds.[62] Among reasons given by human service organizations:

- allows local bias and turf struggles to influence decision-making;

- competition between sophisticated and unsophisticated community groups;
- difficulty of funding new programs or services when local funding patterns are established;
- too many squeaking wheels getting oiled; and
- unpopular client groups can be underserved.[63]

The uses of performance data to mitigate the role of politics are, on the whole, only in the beginning stages. Although county administrators and the public at large place a high premium on outcome measures and evidence of service effectiveness, this data is scarce amd not uniformly available. Ramsey County has instituted a sophisticated and highly regarded evaluation system and Hennepin County is engaged in a strategic planning process. How the data derived from these efforts are used in negotiations with providers has not yet been studied.

RESPONSES TO THE BUDGET CRUNCH: COMMUNITY-BASED FACILITIES' PERSPECTIVE

In this complex environment, high level anxiety by both the threat and realities of the budget crunch surrounded the directors of community-based facilities. A range of responses was uncovered in this study.

- Declining referrals resulted in a search for new clients by changing the goals of the facility. For example, some directors noted they would emphasize treatment of "victims," not "perpetrators"; others planned to seek adult clients with private reimbursement potential; still others planned to initiate "family focused" services in order to capture a broader group of clients.

- In response to anticipated budget cuts, most directors were attempting to diversify their funding sources. Foundations, the United Way, patient fees, and insurance benefits were all sources of substitute funding. In some cases families were being asked to pick up transportation costs; in other situations referrals were being made to other facilities. The elimination of services to children, adolescents, and young men and women from "working poor" families, detached from group health organizations and insurance benefits, was persistently noted. This group was described as the genuine victim of fiscal austerity in the community-based facilities system.

- In response to increased demands for accountability ("when dollars go down, accountability goes up"), client admissions were changed. In fact, it was asserted that in order to document "effectiveness," only "easy" clients would be accepted in order to provide positive evaluations. Illustratively, troublesome youngsters with complex histories could be rejected in favor of clients who could respond to treatment on a short term basis.

- A pervasive adaptation to the fiscal pressures was to move the uses of community-based facilities from a preventive to a crisis orientation. Persons referred to these facilities were generally described as seriously dysfunctional. For example, there was an increase in the number of young persons (between 18 and 22) whose families could not deal with their psychotic behaviors was noted; sexual assault victims seeking help tripled in number; and, while requests for placement of disturbed adolescents appeared to have leveled off, the current requests described severely dysfunctional behaviors.

- Budget cuts were absorbed by reduction of personnel, and this added to the problems since the staff cuts came at a time when the clients were in need of services that required more personnel.

- Nevertheless, most community-based facilities tried to maintain themselves. Closures were resisted.

FLEXIBILITY, STABILITY AND INNOVATION

From their inception, annual contracts with a network of providers of services in community-based facilities were hailed as the only way large, bureaucratic organizations could ensure flexibility. The need to have options for change could be perceived as arising from two principal conditions: client needs (stemming from a change in demography) and philosophical changes in treatment plans (the need to try new approaches); and budget requirements, the loss of dollars, as in 1981-82; or the political choice of shifting dollars from one vulnerable population to another.

The fact that several facilities were closed during the 1981-82 budget crunch is evidence that the purchase-of-service arrangements can respond quickly to budgetary and client changes. As budgets eased in 1982-83, annual contracts could also restore cuts. This attests to the flexibility of the system.

There is a price to be paid for this flexibility, however: it creates a highly unstable environment. It creates serious administrative problems for directors of community-based facilities in trying to keep a program going. "You can't put kids on ice while you wait for programs to reopen," one adolescent facility director noted, "and you can't put workers on shelves in storage."

Those facilities that are offshoots of older, traditional agencies may be in a better position to absorb the shock of closure because they can move staff and services to other units. The same may be said for franchised-style facilities, where staff and programs can be combined into other facilities.

The free-standing facility is the one most at risk in the vagaries of annual contracting, and since many of these facilities come into the market because of their fresh responses to emerging needs, there is cause for concern about their capacity to survive a turbulent budget scene.

To some extent, flexibility in terms of closing facilities is, in fact, constrained by politics. There appears to be an acceptance of the political realities: a planning decision to cancel or substantially modify, downward, a budget for a community-based facility may be, and often is, overruled by a county commissioner. While the county, undoubtedly, holds the purse strings, the environment for the negotiation of contracts is often perceived to be one that is driven by vendors and their political protection. The role of organized advocacy is considered a prime factor in the politics of decision-making.

Can the purchase-of-service options encourage innovation to respond to the variety of circumstances that surround vulnerable populations?

Certain rigidities are rooted in the standards set forth by licensing requirements. The specificity of rules which govern facilities may inhibit innovation. Further, while keeping providers on a short leash via annual contracts is in the county's interests, the entrepreneurial spirit may be chilled by an environment that is perceived to be too unstable. To some extent, county administrators attempt to soften the jolts of budgets in a time of retrenchment by keeping some facilities at a bare minimum level of maintenance pending brighter fiscal times. But inevitably, adversarial tensions exist in the process of contract negotiations. This is not a hospitable environment for innovation or the search for fresh vendors.

Will the "hassle" of dealing with purchase-of-service agreements erode the relationship of community-based facilities with the county to the extent that some

county client groups will find the door to community-based facilities closed to them?

In the final analysis, community-based facilities exist within a dynamic system that is continually redefining its needs and responses. It is fair to say that at times of financial crisis, the county tends to become "accountant driven," searching for ways to maximize reimbursement for services that will relieve the need for local dollars. The effect is to cast a sharp scrutiny on the purchase-of-service agreements, elimina-ting some, cutting budgets on others, shifting allocations from one group to another. In this highly unstable environment, an intense preoccupation with survival absorbs the directors of community-based facilities.

The memory of the "panic" of 1981-83 has had its effects: the determination of directors of community-based facilities to secure funding outside of the county contracts, in order to achieve fiscal stability and independence from fluctuating public dollars. The recognition that counties are paying less and demanding more in accountability and evaluation has also chilled relationships between providers and the county. Negotiations of contract settlements have become slow and arduous. The amount of time that county personnel must spend in providing technical assistance is of increasing concern.

The move to diversify funding sources in order to reduce dependence on the county appears to be an enduring consequence. Indeed, there is a perception that the urban counties are now having a problem in attracting vendors for specialized services and that the pre-1981 eagerness to develop contracts with the counties has diminished considerably. "The provision of services for the seriously handicapped person, the seriously disturbed adolescent, the troublesome mentally ill person is drying up," according to one seasoned observer. Indeed, there appears to be a problem in securing <u>new</u> providers for responding to very difficult clients and specialized services. The "creaming" effect appears to be taking place; the "easy" clients with private fees secure preferential access to community-based facilities.

Although the purchase-of-service system is firmly entrenched as a permanent feature of counties' delivery of human services, many observers inside and outside of county government are beginning a reassessment. Questions are being raised as to whether there are some vulnerable populations and some facilities that might be more cost-effective and responsive if they were, once again, run by the county.

A FINAL ANALYSIS: 1985

Clearly, the purchase-of-service system is in large part a success, yet it faces yet another jolt with the impending cuts coming from the 1986 federal budget. Counties will try even harder than in the past to get their money's worth from purchased programs. The effect on clients cannot be quantified with precision, but the anecdotal reports from the first round of budget cuts in 1981-83 are disquieting.

A final sorting out of which client groups pay the price of sudden shifts in funding and how the costs are distributed will require further assessments. Another period of sustained inquiry into the purchase-of-service system is in order. A few recommendations are pertinent at this stage.

1. Encourage innovation and the recruitment of new vendors into the field of purchase-of-service by providing a three-year cycle to give new services time to test their usefulness and durability. Create incentives such as a higher per diem rate for "start up" costs.

2. Balance the competing interests among the vulnerable populations in their scramble for funds by ensuring a role of advocacy for each client group. Funding for such advocacy should be identified.

3. Repair the sizeable rift between the "practice community" and the "accounting community" by frequent consultations on changes in the system and a mutual agreement on performance criteria.

4. Amplify the understanding of elected county officials on the complex environment in which community-based facilities thrive. Since counties are not likely to levy enough dollars to satisfy the constituencies of community-based facilities while the retrenchment era persists with its continuing loss of federal and state dollars, the political factors in choosing services and programs among the competing providers should be supplemented by evaluative data in an ongoing exchange between professional staff of the counties and elected county commissioners.

NOTES

1. Omnibus Budget Reconciliation Act, 1981, P.L. 97-35.

2. See Appendix A for a list of community-based facilities providing data.

3. See Community Social Services Act of 1979, Minnesota Statutes, 1984, Chapter 256E.

4. The dividing line between the nonprofit-private and community-based tiers is not always distinct. In the 1960s and 1970s, some traditional nonprofit agencies began developing community-based programs under their auspices. Conversely, some community-based agencies matured, expanded, and created new umbrella agencies of their own.

5. Published by the Community Congress of San Diego.

6. For a detailed discussion of how one county responded to both the Omnibus Reconciliation Act and the General Assistance reductions, see The Impact of State and Federal Changes in Human Services Programs and Funding Levels in Hennepin County: 1982 Year End Report, prepared by the Hennepin County Office of Planning and Development, February 1983. For a review of statewide impacts, see "The Effects of 1981-82 Budget Reductions and Program Changes on Minnesota's Vulnerable Human Service Populations" (mimeographed) prepared by James Franczyk, Minnesota State Planning Agency, Human Services Planning Division, May 1983.

7. These figures were derived from the Purchase-of-Service Office, Ramsey County.

8. Conclusion derived from figures provided by Hennepin and Ramsey counties' purchase of service offices.

9. See, for example, Memo: "Child Placement Limitations," Ramsey County Community Human Services Department, September 24, 1981.

10. Interviews with facility directors were conducted primarily by undergraduate students from a community development class at the University of Minnesota's School of Social Work during the Spring of 1982. The questionnaire used to guide the interviewers is in Appendix C. The interview data were amplified by panel discussions with members of the Minnesota Council of Residential Treatment Centers.

11. From: The Program Status of Minnesota Developmental Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to Welsch Consent Decree, Paper No. 7. St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January 1982, p. 11.

12. More and more health plans are being extended to cover chemical dependency treatment, and some now include a psychiatric treatment clause.

13. In the spring of 1982, income maintenance from the SSI program for the mentally retarded and mentally ill came under attack for allegedly harboring a large number of persons who were ineligible for those benefits. Nationwide reviews led to the removal from the program of almost 50 percent of the persons receiving SSI grants. Following a storm of protest, an appeals process was begun to review the decisions, and it was expected that many of the individuals who had been cut would be reinstated. This period was fraught with anxiety and

uncertainty. Court challenges to the methods of terminating SSI recipients and the elimination of benefits during appeals, which were often lengthy and complex, followed. (See for example, Mental Health Association of Minnesota vs. Margaret M. Heckler, Secretary of the U. S. Department of Health and Human Services, No. 83-1263, November 4, 1983.) This decision from a District Court issued an injunction against the practices of terminating without certain medical assessments and the elimination of benefits during appeals. However, a Supreme Court decision reported in the Minneapolis Star and Tribune, May 23, 1984 ruled in a 5-4 vote that federal judges cannot impose administrative rules on terminations and benefits. Lower court decisions that ordered DHHS to reduce delays and pay interim benefits while eligibility was under review were overturned. For a summary of legal and administrative issues see: "The Federal Report: Trimming Disabled Rolls Still Raises Furor," Washington Post, May 14, 1984. Subsequently, almost 50 percent of those who had been terminated during this turbulent period were restored to eligibility. Rigorous reviews of eligibility continue at this time.

14. After July, 1981, a continuing pattern of decline in requests for out-of-home placements (those governed by Rules 5 and 8) is noted. For the fiscal year 1981, a total of 1,083 requests were made to place individuals in group treatment homes or in residential treatment centers. By the end of fiscal year 1982, this number had declined to 701, an almost 30 percent decrease. (Data compiled by Peggy Wallace, Senior Social Worker, Adult-Child Placement Unit, Community Services Department, Hennepin County.)

    Payments for child placement in out-of-home arrangements were reduced from $20,684,927 in 1981 to $18,178,267 in 1982 (see The Impact of State and Federal Changes in Human Services Programs and Funding Levels in Hennepin County: 1982 Year End Report. Minneapolis: Hennepin County Office of Planning and Development, February 1983, p. 3).

15. For example, Ramsey County in a memo dated September 24, 1981, noting that budgets for community corrections and community human services both had budgets reduced by a million dollars each, limited out-of-home placement to:

    Rule 1: Foster Homes--12 months
    Rule 2: Certified Foster Homes--4 months
    Rule 5: Residential Treatment--6 months
    Rule 8: Group Homes--4 months
    Rule 35: Chemical Dependency Treatment--4 months

16. In 1983 this dropped to 6 percent and dropped again to 5.4 percent for 1984.

17. An increasing number of health plans are extending coverage for chemical dependency and psychiatric treatment. It is estimated that 20 percent of such treatment is now reimbursed by insurance payments.

18. Data are from K.C. Spensley, Executive Director, Community Clinic Consortium.

19. See Appendix E for Department of Human Services definitions of these two rules.

20. DACs are also licensed, currently under Rule 3; eventually they will come under Rule 38.

21. See "Community Social Services Plan Reviews" (mimeographed) a report prepared by Barbara Kaufman, Executive Director of MAVSSA 1981-82, p. 26., Minnesota

Association of Social Service Agencies, St. Paul, Minnesota.

22. Although several investigative task forces and studies have emerged over the past few years, client advocacy as represented by families and relatives of adolescents is absent.

23. Although even here, assessments are disputed from time to time. Recently, allegations have been made in an evaluation of Special Education by the Legislative Auditor's Office that some districts labeled children as "learning disabled" in order to receive more categorical state aid. For a summary of the report see Minneapolis Star and Tribune, "Report Seeks Consistency in Labeling Child Handicap," March 27, 1984, p. 1B.

24. Figures are from a report generated after a one-day inventory conducted by the Department of Public Welfare as a partial requirement for P.L. 96-272, "Minnesota Children in Substitute Care Inventory" (mimeographed) Monitoring and Reporting Section, Minnesota Department of Public Welfare, October, 1982.

25. Standards for Child-Caring Institutions (Department of Public Welfare Rule No. 5) describes those adolescents for whom such residential facilities are designed: "For the purposes of admission, an emotionally handicapped child is defined in this rule as a child who in the judgement of a professional social worker, psychologist, or psychiatrist is exhibiting those symptoms and behavior patterns that are determined to be of such a nature that the child needs the care and treatment given in an institution governed by this rule." This 21-page document also sets forth the rules for licensing facilities. Licensing Division, Minnesota Department of Public Welfare, issued on December 11, 1971.

26. Ann Jaede and Marie Junterman, Out of the House: Report on the Substitute Placement of Juveniles, Executive Summary. St. Paul: Minnesota Criminal Justice Program, November, 1982.

27. Minnesota Department of Public Welfare, "Out of Home Placement of Children: A Departmental Overview," an undated, mimeographed paper.

28. Crime Control Planning Board Staff, Through the Labyrinth: The Juvenile Service Delivery System, April, 1981.

29. Minnesota State Legislature, Out of Home Placement of Children in Minnesota: A Research Report, Research Division, Minnesota House of Representatives, February, 1983.

30. The project was directed by Ira Schwartz, supported by the Northwest Area Foundation, and lodged in the Hubert H. Humphrey Institute of Public Affairs. For a summary of findings see Barry Krisberg and Ira Schwartz, "Rethinking Juvenile Justice," Crime and Delinquency, July 1983, pp. 333-364.

31. Known as the 1985 Minnesota Code for Children and Youth, H.F. 774 and S.F. 753. Hearings were held during the 1985 and 1986 legislative sessions, but no action was taken. This recodification provides for a tri-partite division of court responsibility: Juvenile Court for delinquency; Family Court for children in need of protection and status offenses, and Probate Court for civil commitment. The 1985 code provides for greater court involvement in placement decisions and also severely restricts voluntary placements.

32. Information is from Joyce Pederson, Licensing Division, D.H.S., July 1985.

33. St. Joseph's Home for Children, under the auspices of Catholic Charities, operates a Rule 5 facility, an emergency shelter unit, and a day treatment program. The Wilder Foundation operates five Rule 5 facilities.

34. Following the enactment of CSSA in 1979, "cost of care" for disturbed adolescents was earmarked and kept out of the block. A year and a half later, it was folded back in, and it must now compete with a wide range of other social service needs.

35. From a July 7, 1983 telephone conversation with Robert Speltz, Ramsey County Purchase-of-Service Office. Rule 8, small group homes, focus chiefly on a "supportive" environment and less on "treatment." Generally, Rule 8 facilities are considered less structured than Rule 5 facilities, although distinctions are blurred in many instances.

36. Source: Community Social Services Act--1981 Effectiveness Report, informational bulletin #83-26, Minnesota Department of Public Welfare, April 15, 1983, p. 66.

37. See page 7 this study for political resource differences between Hennepin and Ramsey counties.

38. Reporting and Monitoring Unit, Department of Human Services, State of Minnesota.

39. These facilities, which have expanded since 1983, are intended to provide time in a brief interval--18 hours to 45 days--for diagnosis and planning. The intent is to keep children out of long term care.

40. Because of the enormous costs attached to residential treatment, many insurance policies will not cover treatment lasting beyond six months. Insurance reimbursements still comprise a small portion of the average Rule 5 facility's total income.

41. "Students in the SDRS [Student Data Reporting System] System" (mimeographed) July 10, 1985, p. 2. Report available from the Minnesota Association of Volunteer Social Service Agencies, St. Paul, Minnesota, 55104.

42. Public Law 96-272 mandates a six-month administrative review for every child in out-of-home placement. Rule 5 facilities are required to file quarterly reviews, and placement coordinators also do regular reviews.

43. Minnesota Statutes, 1984, Chaper 256E.

44. For a full account, see The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to the Welsch Consent Decree, Paper No. 6. St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January, 1982.

45. A. Corazzo, Activity Centers for Retarded Adults, Washington, D. C.: President's Committee on Mental Retardation, 1972, p. 9.

46. G. Bellamy, R. Horner, and S. Boles, "Community Programs for Severely Handicapped Adults: An Analysis," Journal of the Association for Severely Handicapped, 5(4), 1980, p. 309.

47. For a full account, see The Financial Status of Minnesota Developmental

Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to the Welsch Consent Decree, Paper No. 6. St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January, 1982, p. 19.

48. Community Social Services Act--1981 Effectiveness Report, Informational Bulletin #83-26, April 15, 1983, p. 66, Minnesota Department of Public Welfare.

49. For a full account, see The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to the Welsch Consent Decree, Paper No. 6. St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January, 1982, p. 4.

50. Ibid, p. 17.

51. Interview data from surveys carried out in the spring of 1982.

52. See: Summary of Provisions of Consent Decree in Welsch v. Noot (Legal Aid Society of Minneapolis: Legal Advocacy for the Developmentally Disabled), September 15, 1980; Report of the Monitor to the United States District Court (District of Minnesota, Fourth Division: Reports on the Welsch Consent Decree), published semiannually (available from the Minnesota Department of Public Welfare); Policy Analysis Series: Issues Related to Welsch v. Noot.

53. For a full account of the issues involved, see the Minnesota DD Law Report, Volume I, No. 5 (January 1983), p. 2, Legal Advocacy for Developmentally Disabled Persons in Minnesota and Minnesota Mental Health Law Project.

54. Section 2176 of the 1981 Reconciliation Act allows for waivers to existing statutory requirements to permit states to finance, through the Medicaid program, noninstitutional services for elderly and disabled persons who would otherwise require institutional care.

55. Minnesota has one of the highest ICF/MRs utilization rates in the country. Among individual counties, this rate varies widely.

56. See "The Home and Community-Based Services Waiver Legislation: A Preliminary Analysis" (mimeographed) The Association of Residences for the Retarded in Minnesota, June 17, 1983.

57. See proposed Rule 9525.1330 for details.

58. The McKnight Foundation grant, to be matched 1 to 3 over a period of five years, was awarded to existing organizations of the developmentally disabled to strengthen community support systems. For details of the court order which preceded this grant, see The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to the Welsch Consent Decree, Paper No. 6. St. Paul: State Planning Agency, Governor's Planning Council on Developmental Disabilities, January, 1982.

59. A McKnight Foundation grant of almost $3 million (a matching grant) over a span of years from 1981 to 1984 to Hennepin County for improving community support systems for the mentally ill did direct some dollars to child and adolescent treatment but these dollars went chiefly to outpatient treatment facilities.

60. See, for example, Office of the Legislative Auditor, Program Evaluation Division,

State of Minnesota, Attitudes About Minnesota's Block Grants Among County Commissioners, Block Grant Administrators, and Interest Group Representatives. St. Paul, MN: April 1984.

61. Ibid., Table 1, page 2.

62. Ibid., Table 23, page 19.

63. Ibid., pp. 99-100.

APPENDICES

APPENDIX A. COMMUNITY-BASED FACILITIES THAT PROVIDED DATA FOR THIS STUDY

I. Youth Chemical Dependency

1. #71 New Connections
2. #48 Omegon
3. #52 Shanti House
4. #66 Renaissance

II. Adult Chemical Dependency

1. #53 Turning Point
2. #58 Chrysalis
3. #51 NuWay House Incorporated
4. #69 New Visions Treatment Center
5. #36 Winaki House
6. #54 Wayside House

III. Adult Chronic Mentally Ill

1. #26 Project Independence
2. #25 Project Overcome
3. #30 Tasks Unlimited
4. #34 Hope Transition Center
5. #81 Sharing Life in the Community
6. #28 Cooperative Work Transition Program
7. #61 Youth Emergency Services (Y.E.S.)
8. #72 Petra Howard House
9. #31 Wellspring

IV. Developmentally Disabled

1. #18 Merriam Park Community
2. #41 Greenhaven Heights DAC
3. #42 Kaposia
4. #43 Merrick DAC
5. #46 St. Paul's DAC (St. Paul on the Hill)
6. #45 Midwest Special Services Incorporated
7. #83 Aid Homes
8. #85 Nekton Incorporated
9. #82 Aurora House

V. Physically and Mentally Handicapped

1. #77 Minnesota Epilepsy League
2. #44 St. Paul Rehabilitation Center
3. #27 People Incorporated

VI. Adolescent Services

- Agencies Serving Both Males and Females

1. #01 Alternative Homes
2. #21 Family Alternatives
3. #38 The City
4. #76 Pathway Group Homes
5. #68 Home Away Shelter Incorporated
6. #57 The Bridge
7. #24 Family Networks Incorporated

- Agencies Serving Primarily Male Adolescents

1. #02 Arlington House
2. #73 Freeport West
3. #70 Bar-None Boys Ranch
4. #75 Jonathan Group Homes
   (As of July 1, 1982, no longer in service)

- Agencies Serving Primarily Female Adolescents

1. #05 Friendship House - Lutheran Social Services
2. #16 Home of the Good Shepard
3. #56 Zion Northside Group Home
   (As of July 23, 1982, no longer in service)
4. #78 New Life Homes

VII. Neighborhood Health

1. #11 Freemont Community Health Services
2. #12 Family Tree Incorporated
3. #09 West Side Community Health Center
4. #08 Teenage Medical Clinic
5. #13 Community-University Health Care Center
6. #14 Peoples Center
7. #15 Beltrami Health Center
8. #86 Neighborhood Involvement Program
9. #62 Annex Teen Clinic
10. #64 West Surburban Teen Clinic
11. #10 Uptown Community Clinic

VIII. Women in Vulnerable Situations

1. #19 Alexandra House
2. #22 Women's Advocates
3. #23 Harriet Tubman Women's Shelter
4. #63 Home Free
5. #20 Domestic Abuse Intervention Project
6. #35 Christopher Street
7. #39 Survival Skills Institute Incorporated

IX. Miscellaneous

1. #17 Refugee Resettlement Program - Lutheran Social Service

APPENDIX B. HENNEPIN AND RAMSEY COUNTIES FUNDING FOR SERVICES FOR THE CHEMICALLY DEPENDENT, 1981-1985

HENNEPIN COUNTY	1981	1982	1983	1984	1985
NONRESIDENTIAL					
Chemical Dependency Intervention/Minorities*					
Am. Indian Diversion	$ 16,844	$ 17,440	$ 18,349	$ 19,487	$ 20,461
Indian Neighborhood	49,090	46,806	49,227	--	--
MN Inst./Black CD (adult)	162,999	172,337	181,252	--	--
MN Inst./Black CD (youth)	110,365	117,172	123,233	--	--
MN Inst./Black CD (combined)	--	--	--	323,209	339,370
Centro Cultural Chicano	104,640	104,640	110,048	109,370	107,713
Primary Outpatient					
Person Education Develop.	28,520	28,518	29,254	30,833	31,745
Minneapolis Age & Opport.	40,000	43,600	45,853	48,700	51,135
On Top	35,500	30,000	44,649	50,955	58,160
Drug Abuse Serv. (MRC DASP)	90,733	73,290	79,027	105,135	115,390
Create	50,000	30,500	32,076	51,606	54,180
Eden Day Adult	164,609	174,675	186,401	197,958	221,636
Chrysalis--Access**	--	--	84,577	91,068	100,014
Chrysalis--Outpatient**	--	19,084	176,336	83,400	87,570
Methadone Maintenance	--	--	--	--	--
CD Aftercare/Adolescents					
Minneapolis Public Schools	122,604	100,000	105,169	111,500	117,130
Henn. Area Youth Diversion***	49,376	--	--	--	--
Minneapolis Youth Diversion	--	74,341	183,468	205,228	215,487
TOTALS: NON-RESIDENTIAL	1,025,280	1,132,403	1,448,919	1,428,449	1,519,991
RESIDENTIAL					
Halfway Houses					
New Visions Treatment Ctr.	471,073	481,177	400,852	411,028	421,365
Eden Residential	274,708	310,243	343,104	348,383	386,050
Prodigal House	79,951	82,053	82,326	90,413	94,934
Omegon (Pharm House; youth)	157,859	149,130	156,839	166,563	174,891
Mission Lodge (formerly Vanguard)	153,609	167,434	176,220	119,869	135,488
Shanti House (youth)	189,227	206,257	217,080	214,339	216,319
Wayside House	220,165	239,980	252,573	268,233	281,645
NuWay House	117,510	128,814	133,750	148,759	158,483
Winaki	81,171	88,476	92,344	98,069	closed
American Indian Services	99,243	104,202	109,608	116,404	122,224
Turning Point	109,000	114,754	134,526	178,016	218,874
TOTALS: RESIDENTAL	$1,953,516	$2,072,520	$2,099,222	$2,160,076	$2,210,273

*Also serves a general population.
**Chrysalis Access is for diagnosis/referral. Chrysalis Outpatient had State Block Grant funds.
***These HAYDP organizations split up and had separate contracts after 1981.

RAMSEY COUNTY	1981	1982	1983	1984	1985
NONRESIDENTIAL					
CD Intervention/Minorities					
MIBCA	$ 67,056	$ 63,682	$ 63,900	$68,880	$ 72,463
CASA-Hispano	111,055	68,907	66,748	62,126	79,198
Juel Fairbanks	34,020	33,300	33,300	35,964	37,762
Primary Outpatient					
Exchange Granville	50,635	45,500	45,500	47,403	77,351
Methadone Maintenance					
Hennepin County	27,229	24,421	34,799	36,495	46,200
CD Aftercare/Adolescents					
Moundsview #621	46,983	34,106	34,094	44,268	46,481
St. Paul #625	32,030	27,024	27,835	30,764	38,362
P.E.D.E.	18,198	14,370	14,346	15,520	16,296
TOTALS: NON-RESIDENTIAL	387,206	311,310	320,522	341,420	414,113
RESIDENTIAL					
Halfway Houses/CD					
Hazelden-Fellowship	68,448	55,845	55,841	34,640	70,247
Granville-Dickman	67,706	37,835	42,536	55,068	} 135,204
Granville-Team	97,654	75,924	54,042	72,319	
Juel Fairbanks	98,357	81,597	69,489	78,886	41,424
People, Inc.--Dayton	59,996	56,535	73,686	85,868	99,471
Union City Mission	20,235	9,234	--	--	--
Intervention for Adolescents					
Intercept-Granville	103,197	54,300	62,129	54,900	56,829
Intervention for the Elderly					
Ramsey Clinic Associates	81,000	72,900	19,800	19,800	19,800
TOTALS: RESIDENTIAL	$ 596,593	$ 444,170	$ 377,523	$ 401,481	$ 422,975

APPENDIX C. QUESTIONS USED FOR INTERVIEWS WITH DIRECTORS OF COMMUNITY-BASED FACILITIES

Name of Student_____Name of Agency_____
Person Interviewed_____Title_____Phone_____

Interview Schedule for Non-Profit Agencies

These questions are intended to provide information on how non-profit agencies are affected by recent budget changes: how budget modifications affect their clients, personnel, and programs.

These columns for statistical use only.

Here are some questions about the nature of your agency. ___ ___ 01 02

What are the primary services offered by your agency?

residential care_____ ___ 03

counselling _____ ___ 04

support services _____ ___ 05

health services _____ ___ 06

other _____ ___ 07

Comments: _____

_____

_____

What are the characteristics of your clients?

sex _____ ___ 08

age _____ ___ 09

income _____ ___ 10

what counties do your clients come from

_____

_____

_____ ___ ___ ___ 11 12 13

nature of presenting problems _____ ___ 14

How many persons did you serve last budget year?

_____ ___ ___ ___ ___ 15 16 17 18

Average length of service (in months)?_____ ___ ___ 19 20

Comments:_____

_____

_____

Funding Questions

These questions are intended to identify the sources of your agency budget for the current budget year.

What is your budget year? from_____to_____

What percent of your current budget comes from public funds?

_____ 21 22

What percent of your budget comes from private funds?

_____ 23 24

Do you receive any money from 3rd party reimbursements (private insurance through group plans)?

_____ 25

If so, what proportion of your budget comes from this source of funding?

_____ 26 27

Do you have any comments on the way your programs are funded?

_____
_____
_____

Contingency Plans

If you have suffered cuts, or know you will in the next budget year, perhaps you have plans for making up the cuts.

1. Have you contacted (yes or no) a) Foundations _____ 28

b) Corporations_____ 29

c) United Way_____ 30

With what result_____ 31
_____
_____

2. Here are some other ways agencies are making up the cuts. Do you plan to:

a) install a fee for service _____ 32

b) increase membership fees _____ 33

c) use volunteers _____ 34

d) raise funds through a special drive _____ 35

e) eliminate services _____ 36

f) freeze salaries _____ 37

g) eliminate staff _____ 38

h) other _____ 39

Comments: _____

_____

_____

Program Questions

For each of the following typical program components, what is the effect of reductions in your budget? Are they being maintained without change, reduced, or eliminated?

	maintained w/o change	reduced	eliminated	
1. client services				40
2. needs assessment				41
3. outreach				42
4. information & referral				43
5. staff training/travel				44
6. monitoring/evaluation				45
7. improvement of facilities				46
8. other				47

Comments: _____

_____

_____

Personnel Questions

What is your present staffing pattern?

	Full-time	Part-time	
1. Executive Director/Management	_____		48
2. Direct Service Workers	_____	49	50
3. Support Staff/Clerical/Janitorial	_____	51	52
4. Consultants	_____		53

Comments: _____

_____

_____

Changes in Staffing Patterns

If you have experienced cuts, or expect to, how will this affect staffing patterns?

	Management	Direct Service Workers	Clerical	
1. Full-time to part-time	_____			54
2. Resignations	_____			55
3. Layoffs	_____			56
4. Reduction by attrition	_____			57
5. Eliminating functions	_____			58

If so, which ones? _____

Comments: _____

_____

_____

Changes in Client Services

If you have already suffered cuts, this may have affected your services to clients in several ways.

1. Will you be able to serve the same number of persons next fiscal year? _____ 59

   If fewer, how many will you be unable to serve? _____ 60 61

2. Will you change eligibility? _____ 62

   If so, how?_____

   _____

3. Will you make referrals to other agencies? _____ 63

   If so, where? _____

   _____

4. Have placing agencies made new requirements on your agency? _____ 64

   If so, what are the new conditions?_____

   _____

Comments:_____

_____

_____

Changes in Client Need for Services

Here are some ways in which clients are showing their increased need for services. Which ones has your agency noted? (yes, no, or not applicable)

1. Increased requests for income maintenance assistance ____ 65
2. Transportation problems ____ 66
3. Utility problems ____ 67
4. Housing problems ____ 68
5. Difficulty in paying fees ____ 69
6. Increased incidence of crisis situations ____ 70
7. Child care problems ____ 71
8. Homemaker problems ____ 72

9. Counselling ____ Please elaborate: _____ 73
_____

10. Presenting more serious problems ____ 74

11. More previous placements ____ 75

12. More parental involvement ____ 76

13. Changed referral source ____ 77

14. Other ____ Please specify: _____ 78
_____

Comments:_____ Columns 79-80
_____ Blank
_____

Open Questions:

1. Can you comment on the kinds of hardships your clients endure because of budget cut-backs?

2. What will be the eventual outcomes?

3. Any other comments:

Thank you for your time.

APPENDIX D. ADMISSION POLICY CHANGES FOR MINNESOTA DACS, 1980, 1981, 1982*

Infant/Preschool Admission Policy Changes for 1981	N
Preschool programs were discontinued	3
Programs emphasized "non-maintenance" persons	1
Admission dependent upon meeting more categorical criteria, e.g. physician's referral; MR or CP diagnosis	3
Behavior problems, one-to-one staffing needs more closely evaluated	1
Administrative procedures streamlined	2
Needs of more severely disabled given higher priority	4
	14

Infant/Preschool Admission Policy Changes for 1982 (Anticipated)	N
Programs to emphasize more severely handicapped children	4
More severely disabled children might receive lower priority	2
Preschool or homebound programs discontinued	3
Reduction in program options or hours for clients, e.g. fulltime services	3
Will initiate a fee schedule	1
	13

Infant/Preschool Demission Policy Changes for 1981	N
Placed greater emphasis upon attendance by clients	2
Less severely disabled children were more likely to be demitted	1
	3

Infant/Preschool Demission Policy Changes for 1982 (Anticipated)	N
Children with less severe disabilities may no longer be eligible for DAC services	1

Adult Admission Policy Changes for 1981	N
Admission criteria more responsive to county mandates, e.g. client needs for services, number of county residents served, and transportation	4
Closer scrutiny of client ages, e.g. trial admissions for people over 65 years old	5
Lower functioning applicants given higher priority	1
Behavior problems scrutinized more closely	2
Client capacity to benefit evaluated more closely, e.g. "maintenance" and ability to progress, part-time programming	5
	17

*100 percent reporting.

SOURCE: The Program Status of Minnesota Development Achievement Centers: 1980-1982. Policy Analysis Series: Issues Related to the Welsch Consent Decree, Paper No. 7. St. Paul: State Planning Agency, Governor's Council on Developmental Disabilities, January 1982, p. 19.

APPENDIX E. DEFINITIONS FROM THE DEPARTMENT OF HUMAN SERVICES

Organizations and Groups Subject to Licensing

Rule 4 Voluntary Child Caring/Child Placing Agencies

An agency means any individual, organization, association or corporation planning for, giving direction to, or providing needed service or assistance to children and parents in their own homes; or receiving children unable to remain in their own homes and placing them in foster care; or receiving children and placing them in foster care; or receiving children and placing them for adoption. An agency includes any social service department of a child-caring institution carrying these responsibilities or giving these services. An agency may be licensed as "caring" or "placing" or both.

Group Residential Programs

Rule 5 Child-Caring Institution: any program for the care and treatment of eleven or more children on a 24-hour per day basis who are emotionally and/or socially handicapped.

Rule 6 Maternity Shelter: any residential program providing 24-hour per day care for three or more pregnant women, including women who have recently been delivered of a child. It does not include facilities giving obstetrical care licensed by the State Department of Health.

Rule 8 Group Homes for Children: a specialized facility providing care on a 24-hour basis for not more than ten children. The facility provides a planned treatment program under the direction and control of an agency, institution, or independent operator. Natural children of the group home parents, if present in the home, are included in the total number of children living in the home.

Rule 34 Residential Programs and Services for Persons Who Are Mentally Retarded: any program for the care and treatment of five or more mentally retarded persons on a 24-hour per day basis.

Rule 35 Residential Programs for Inebriate and Drug-Dependent Persons: any program for the care and treatment of five or more inebriate or drug-dependent persons on a 24-hour per day basis.

Rule 36 Residential Programs for Adult Mentally Ill Persons: any program for the care and treatment of five or more adult mentally ill persons on a 24-hour per day basis.

Rule 80 Residental Programs and Services for the Physically Handicapped: any program for the care and treatment of five or more physically handicapped persons on a 24-hour per day basis.

SOURCE: Department of Public Welfare, Bureau of Support Services, Division of Licensing, December 10, 1981.

Group Day Care (Non-Residential) Programs

Rule 3 Group Day Care Centers: any program providing care for six or more children away from their own homes for part of the 24-hour day. This includes all-day programs, nursery schools, Head Start programs, and cooperatives.

Rule 3 Developmental Achievement Centers: any program providing care and training for five or more mentally retarded or cerebral palsied persons away from their own homes for part of the 24-hour day.

Rule 18 Semi-Independent Living Services to People Who are Mentally Retarded: any person, organization or association providing a system of services to mentally retarded adults on a less than 24-hour per day basis. The services may include training, counseling, instruction, supervision and assistance needed to maintain and improve the client's functioning.

Rule 43 Out-Patient Programs for Chemically Dependent Persons: any program providing outpatient treatment to five or more persons with alcohol or other drug problems.

Family Licensing Programs

Rule 1 Family Foster Homes and Group Family Foster Homes: any program providing care for no more than five children (ten for Group FFH's) away from their own homes on a 24-hour per day basis.

Rule 2 Family Day Care Homes and Group Family Day Care Homes: any program providing care for no more than five children (ten for Group FFH's) away from their own homes for part of the 24-hour day. Natural children of the family day care provider(s) under school age are included in the total number of children in care.

SUMMARY OF RULES BY WHICH THE DIVISION LICENSES

DPW Rule 1 - Family Foster Care and Group Family Foster Care

DPW Rule 2 - Family Day Care and Group Family Day Care

DPW Rule 3 - Group Day Care Centers and Developmental Achievement Centers

DPW Rule 4 - Child Caring or Child Placing Agencies

DPW Rule 5 - Child Caring Institutions

DPW Rule 6 - Maternity Shelters

DPW Rule 8 - Group Homes for Children

DPW Rule 18 - Semi-Independent Living Services for People Who Are Mentally Retarded

DPW Rule 34 - Residential Facilities and Services for the Mentally Retarded

DPW Rule 35 - Residential Programs for Inebriate and Drug Dependent Persons

DPW Rule 36 - Residential Programs for Adult Mentally Ill Persons

DPW Rule 43 - Outpatient Programs for People with Alcohol and Drug Problems

DPW Rule 80 - Residential Facilities and Services for Physically Handicapped

APPENDIX F. PURCHASE-OF-SERVICE FUNDING FOR CHEMICAL DEPENDENCY TREATMENT IN HENNEPIN AND RAMSEY COUNTIES, 1981-1985

Hennepin County	1981	1982	1983	1984	1985
Non-Residential Treatment (17 contracts)*	$1,025,280	$1,132,403	$1,448,919	$1,428,449	$1,519,991
Per capita	1.09	1.20	1.54	1.52	1.61
Residential Treatment (11 contracts)*	1,953,516	2,072,520	2,099,222	2,160,076	2,210,273**
Per capita	2.08	2.20	2.23	2.29	2.35
TOTALS (Absolute)	$2,978,796	$3,204,923	$3,548,141	$3,588,525	$3,730,264
TOTALS (Per capita)	3.16	3.40	3.77	3.81	3.96

AVERAGE, 1981-1985 (Absolute): $ 3,383,700
AVERAGE, 1981-1985 (Per capita): $ 3.59

Ramsey County					
Non-Residential Treatment (8 contracts)*	$387,206	$311,310	$320,522	$341,420	$414,113
Per capita	.84	.67	.70	.74	.90
Residental Treatment (8 contracts)*	596,593	444,170	377,523	401,481	422,975
Per capita	1.30	.97	.82	.88	.92
TOTALS (Absolute)	$983,799	$755,480	$698,045	$742,901	$837,088
TOTALS (Per capita)	2.14	1.64	1.52	1.62	1.82

AVERAGE, 1981-1985 (Absolute): $ 803,463
AVERAGE, 1981-1985 (Per capita): $ 1.75

*See Appendix B for listing of individual contracts.

**One residential center, funded at about $92,000 in 1983 and about $98,000 in 1984, closed in 1985.

SOURCE: Based on population figures for Hennepin and Ramsey counties from the 1980 Census.

APPENDIX G. FUNDING FOR RESIDENTIAL ADOLESCENT SERVICES IN HENNEPIN AND RAMSEY COUNTIES, 1981-1984

HENNEPIN COUNTY	1981	1982	1983	1984
Rule 5 Facilities*				
1. Frendship House	$ 582,628	$ 634,399	$ 517,848	$ 521,477
2. The Bridge	203,457	217,978	229,208	243,465
Rule 8 Facilities**				
1. The City/Southside	111,168	121,626	133,933	152,618
2. Zion Northside Group Home	162,863	178,901	closed	--
3. Home Away Shelter (girls)	348,272	409,503	400,977	404,698
4. Freeport West	209,919	232,870	247,931	296,273
5. New Life Homes	202,181	221,584	--	--
6. Pathway Group Homes (two facilities)	279,736	302,220	193,982	214,073
7. Friendship House II	148,745	159,027	168,652	179,589
8. Harambe Community	168,210	189,522	202,330	214,137
9. Home Away	880,077	930,020	922,763	1,010,930
10. Lincoln House West	255,376	287,974	302,731	336,866
11. On-Belay	$ 143,106	$ 174,561	$ 185,421	$ 192,356

*The Bridge was converted to an emergency shelter in 1982-83.

**The Zion Northside Group Home was closed in 1982-83; Home Away Shelter was changed to an emergency shelter; Pathway closed one of their two group homes and capacity dropped from 16 to 10.

SOURCE: Purchase of Service Office, Hennepin County; calculated on a calendar year basis. These figures represent the amount contracted as reflected in documents in the Purchase of Service Office.

RAMSEY COUNTY	1981	1982	1983	1984
Rule 5 Facilities*				
1. Alternative Homes	$ 14,446	$ 58,457	$ 16,768	--
2. Arlington House (Treatment)	131,843	85,857	86,482	--
3. Arlington House (Shelter)	158,036	329,648	314,172	319,598
4. Booth Brown House (Treatment)	171,105	171,076	114,578	94,490
5. Booth Brown House (Shelter)	313,206	324,262	309,538	545,424
6. Children's Home Society (Lincoln House East)	--	85,096	34,730	--
7. Directions for Youth (Turning Point)	75,967	160,760	66,583	--
8. Juvenile Horizons	21,485	19,544	7,048	76,041
9. Home of the Good Shepherd	200,589	226,018	104,825	195,101
10. Wilder Bush & Annex	64,259	55,154	18,620	357,133
11. Wilder O'Shaughnessy	143,542	143,258	71,014	54,400
12. Wilder Youth Res. (Holcomb)	19,801	157,086	43,795	12,798
13. Wilder Youth Res. (Spencer)	--	164,058	70,873	--
Rule 8 Facilities				
1. Harambe (closed)	5,067	55,638	120,094	57,567
2. Maria	11,389	34,657	50,305	32,645
3. New Life Homes	13,517	22,085	15,859	3,085
Corrections**				
1. Wilder St. Croix Camp	428,693	758,841	764,204	$ 830,358
2. Tri-House	$ 46,523	$ 66,108	$ 36,797	--

*The following Rule 5 facilities were closed in 1982-83: Arlington House Treatment (closed 3/25/83), Lincoln House East (closed 11/1/82), Turning Point (closed 12/31/82), Spencer House (A. H. Wilder, closed 6/30/82, now used as Bush Center Annex), O'Shaughnessy (A. H. Wilder, closed 8/31/82, reopened 7/1/83).

**Tri-House was closed in 1982-1983.

SOURCE: Office of Purchase of Service, Ramsey County.

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